The CANADIAN HOSPITAL

VOLUME 14
NUMBER 10

OCTOBER
1937

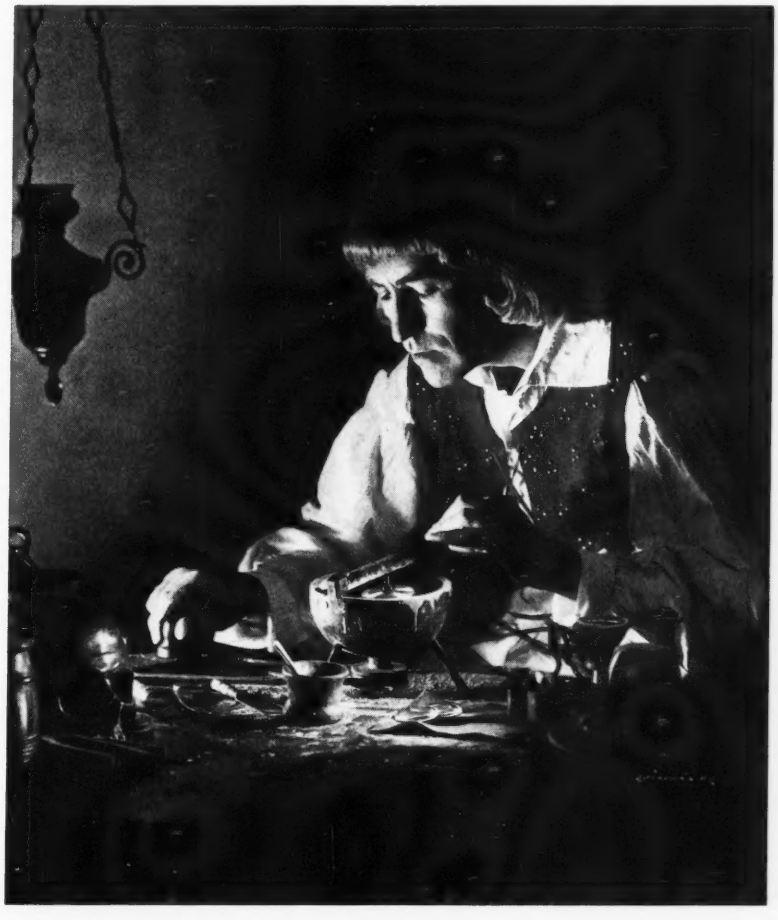
Official Journal
CANADIAN HOSPITAL COUNCIL

Index of Advertisers

CONTENTS

October, 1937

The Canadian Hospital is published monthly by The Canadian Hospital Publishing Co., 177 Jarvis Street, Toronto, Ont. Subscription Price in Canada, $1.00 per year. Authorized by the Post Office Department as Second Class Matter.



SPECIALIZATION

A seventeenth century lens-maker improves the microscope . . . micro-organisms become visible . . . and a chain of discovery follows which revolutionizes surgery. Thus, civilization marches ahead in the footsteps of specialists.

- In the production of surgical sutures, specialization has many advantages. Here improvements come, not by accident, but through long and extensive research.
- Special equipment and the undivided effort of an experienced personnel are vital to the maintenance of present standards.
- Advancement demands a staff fully qualified to apply to our special field all important developments in allied sciences.

Yesterday, today, tomorrow . . . "*This One Thing We Do*". Adherence to this slogan is reflected in the leadership of our products.

DAVIS & GECK SUTURES

DAVIS & GECK, INC., BROOKLYN, NEW YORK, U. S. A.

OBTAINABLE FROM RESPONSIBLE CANADIAN DEALERS.

CYCLOPROPANE ANESTHESIA IN *Obstetrics*

Bourne[1] of McGill University and Knight[2] of the University of Minnesota have found cyclopropane to be of advantage in obstetrical cases. The abundance of oxygen given with cyclopropane—the maintenance of good circulation and respiration and of uterine contraction and tone are factors which make cyclopropane valuable in obstetrics.

As a result of the extreme care exercised in the production of Squibb Cyclopropane the gas is exceptionally pure. This has been an important factor in its acceptance by anæsthetists throughout the country as a safe and effective anæsthetic agent.

Squibb Cyclopropane is now supplied in 30-, 75- and 200-gallon cylinders, and also in 2-, 6-, and 25-gallon Amplons.* The 30-gallon cylinders and the 2- and 6-gallon Amplons are especially suitable for portable machines.

NOTE: Because of the potency of cyclopropane in low concentrations, it is important that the anæsthetist be thoroughly trained in the technique of administering this gas.

For Literature write: Professional Service Dept., 36 Caledonia Road, Toronto, Ont.

E·R·SQUIBB & SONS OF CANADA, LTD
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

*Amplon is a trade-mark of E. R. Squibb & Sons. 1 Bourne, W.: *Lancet*, 2:20 (July 7), 1934. 2 Knight, R. T.: *Anes & Anal*, 15:63 (Mar.), 1936.

Sales tax is NOT included in quotations, as same does not apply when garments are shipped to Approved Hospitals under their purchase orders bearing the required Sales Tax exemption certificate.

CORBETT - COWLEY
LIMITED

PRICE LIST

Effective October 1, 1937. Subject to Change Without Notice, Cancelling All Previous Lists.

Bed Gowns, freight prepaid to your address on lots of 12 dozen or more, or on an assortment of "Hospital Apparel" items amounting to $100.00 or more.

Catalogue Page	Style No.	Price per Doz.	Description
3	113-79	$25.20	Lapel Collar Coat
3	302-79	25.20	Doctor's Pants
4	215-11	25.20	Surgeon's Coat
5	431-99	12.50	Doctor's Operating Gown
5	431-58	13.50	" " "
5	431-56	15.00	" " "
			Above prices are for Operating Gowns with regular hem sleeve. If required with Knitted Cuffs, add $1.00 per dozen.
6	132-56	12.00	Surgeon's Operating Coat
6	311-56	10.80	" " Pant
7	175-56	13.80	" " Shirt
7	176-65	10.80	" " "
8	122-181	24.00	Dispensary Coat
8	122-186	33.00	" "
8	122-194	33.00	" "
9	111-11	20.00	" "
10	101-77	21.00	Dental Laboratory Coat
11	128-89	30.00	" Operating Gown (Sanforized)
12	442-99	12.50	Nurse's Operating Gown
12	442-58	13.50	" " "
12	442-56	15.00	" " "
			Above prices are for Operating Gowns with regular hem sleeve. If required with Knitted Cuffs, add $1.00 per dozen.
13	8150	3.00 each, or 3 for $8.50	Nurse's Uniform, Middy Twill
13	8150	4.50 each, or 3 for 12.00	" " Corley Poplin
14	8250	3.00 each, or 3 for 8.50	" " Middy Twill
14	8250	4.50 each, or 3 for 12.00	" " Corley Poplin
15	8300	3.00 each, or 3 for 8.50	" " Middy Twill
15	8300	4.50 each, or 3 for 12.00	" " Corley Poplin
16	8900	3.00 each, or 3 for 8.50	" " Middy Twill
16	8900	4.50 each, or 3 for 12.00	" " Corley Poplin
17	9502	.35 each, or 3 for 1.00	" Cap, Fine Lawn
18	9001	1.00 each, or 6 for 5.50	" Waist Apron, Sheeting
18	9003	1.50 each, or 6 for 8.50	" Bib Apron, Sheeting
19	9002	.50 each, or 6 for 2.75	" " Single, Sheeting
19	9002	1.00 each, or 6 for 5.50	" " Double, Sheeting
22	456-56	2.50 each, or 3 for 5.00	Hoover style Gown
23	460-65	2.25 each, or 3 for 5.00	" " "
24	459-56	2.00 each, per doz. 15.00	Kimona style Gown
25	9501—Lawn	.35 each, per doz. 3.50	Maid's Cap
26	407-97	7.20	Patient's Bed Gown
26	407-99	9,00	" " "
26	407-58	9.60	" " "
26	407-56	10.80	" " "
28	105-161	21.00	Orderly's Coat
28	301-161	21.00	" Pants
29	179-186	27.00	" Jacket
29	179-194	27.00	" "
29	301-186 or 194	33.00	" Pants
30	121-11	18.00	Chef's Coat
30	553-56	3.60	" Cap
31	304-11	18.00	" Pants
31	304-142	19.50	" "
31	304-143	21.00	" "
32	507	6.00	Bib Apron, 44" long, 36" wide
33	508	5.00	Square or Waist Apron, 38" long, 36" wide
34	201-161	30.00	Butcher's Frock
35	211-56	24.00	Storeroom Frock
35	211-112	24.00	" "
36	301-1	19.20	Men's Pants
36	301-77	21.00	"
37	137-11	15.00	Counterman's Coat
38	179-186 or 194	27.00	Porter's Blouse
38	301-186 or 194	27.00	" Pants
39	509	5.40	" Bib Apron
40	143-40	18.00	Dairy Smock
41	351-40	18.00	" Overall
42	176-56	11.20	" Shirt
43	304-1	18.00	" Pants
43	304-142	19.50	" "
43	304-143	21.00	" "
44	515	8.40	Heavy Bib Apron, 44" long, 44" wide
45	516	7.20	Heavy Square Apron, 40" long, 44" wide
45	552-1	2.40	Dairy Cap
46	105-1	18.00	White Military Collar Coat
47	108-161	21.00	No Collar Coat

The above prices are for garments in our regular stock sizes only.

In the manufacture of all our garments, we certify that they are cut and made under conditions, complying in every particular, with Government regulations, covering hours of labour, sanitation, etc., etc., and that the Minimum Wage Laws in every respect have been, and are rigidly adhered to.

The Minimum Wage Law is observed by us as such, and is not considered as the Maximum Wage. All our products are unconditionally guaranteed as to workmanship and material.

CORBETT-COWLEY
Limited

690 KING ST. W., TORONTO — 637 CRAIG ST. W., MONTREAL

MORE COMFORT FOR PATIENT
Combined with
Greater Simplicity

Can be fitted with adhesive as shown above or held with towel clips while cast bandaging is applied.

"HAS REVOLUTIONIZED THE TECHNIQUE OF ORTHOPRACY"

Says A Doctor Who Has Used

"DUNLOPILLO"

CELLULAR LATEX SURGICAL SHEETS FOR PLASTER CAST PADDING IN MORE THAN 200 CASES

He goes on to state that—"no failures and perfect healing have resulted in each case. Heat sores and bed sores have been eliminated. Cases where the cast has been on a patient ten weeks, when removed showed no signs of sores, and it has not yet been necessary to replace a cast to overcome sores or swelling. Patients are highly appreciative of the comfort of this material."

While the illustration shows the application of a "Spika" cast, "DUNLOPILLO" Cellular Latex Surgical Sheets are equally satisfactory for padding all types of body casts, shoulder casts, aeroplane splints, arm splints, leg casts, etc.

"DUNLOPILLO" Cast Padding Material may be purchased from the following medical supply houses:—

J. E. Livernois Ltd., Quebec, P.Q.
Casgrain & Charbonneau, Montreal, P.Q.
Cloutier & Cloutier Cie., Ltee., Montreal, P.Q.
J. F. Hartz Co. Ltd., Toronto and Branches.
Ingram & Bell Ltd., Toronto and Branches.
J. Stevens & Son Co., Toronto and Branches.
Surgical Supplies of Canada Ltd., Toronto, Ontario.
The Metal Craft Co. Ltd., Grimsby, Ontario.
The Standard Tube Co. Ltd., Woodstock, Ontario.
Geo. S. Trudell & Co., London, Ontario.
Fisher & Burpe Co. Ltd., Winnipeg and Branches.

"DUNLOPILLO" Operating Table Pads have comfortable resiliency which induces relaxation, at the same time providing requisite firmness. Definitely germ-resisting and by nature slightly antiseptic.

Other "DUNLOPILLO" Sick Room Accessories:

MATTRESSES
LEG CUSHIONS
STRETCHER PADS
RING CUSHIONS
EXAMINING TABLE PADS
CRIB MATTRESSES
BASSINETTE MATTRESSES
WHEELCHAIR SEAT CUSHIONS
AMBULANCE MATTRESSES

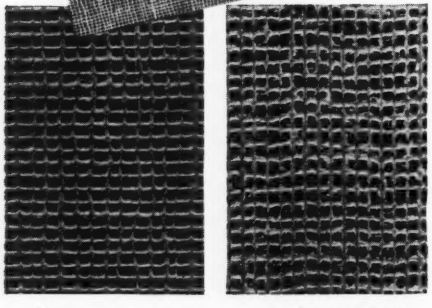
DUNLOP-CANADA

BRANCHES AND SALES OFFICES:

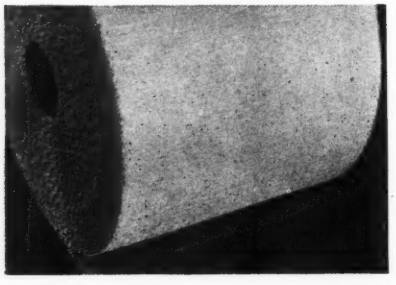
Halifax
Saint John
Quebec
Montreal
Ottawa
TORONTO
Hamilton
London
Windsor
Winnipeg
Regina
Saskatoon
Calgary
Edmonton
Vancouver
Victoria

NOW — a New CRINOLINE

THAT IMPROVES PLASTER CAST TECHNIQUE



Note, in these micro-photos, that the sizing in OSTIC Crinoline does not "pile up" at thread intersections, clogging up the mesh as in the ordinary fabric at the right. Every mesh, therefore, receives and retains a maximum of Plaster of Paris. Each bandage delivers more plaster to the cast. Fewer bandages to handle, less crinoline used—time and material saved!



By combining new ingredients into an entirely different type of sizing formula, Bauer & Black has produced a plaster bandage crinoline with definitely improved characteristics. The new OSTIC Crinoline makes possible the production of better casts and offers advantages that benefit the surgeon, the patient and the hospital.

DELIVERS MORE PLASTER TO THE CAST

Because the meshes of OSTIC Crinoline are not clogged by sizing, an appreciably greater amount of dry plaster is incorporated into the bandage. The wet plaster is held to the cloth in a firmer mechanical bond because of a more irregular sizing surface—more plaster is conveyed to the cast.

GREATER CAST STRENGTH

OSTIC Crinoline makes two new contributions to the most important factors governing cast strength. First, it is unique in offering no interference with a firm, hard set. Second, there is no viscous material in the sizing to impede the escape of excess water. Drying time is reduced to a minimum. The shorter drying time offers less opportunity for the patient to put a strain on the still-damp cast, causing a structural defect that will later be a weakness in the dry cast.

BAUER & BLACK LIMITED
STATION K. TORONTO, CANADA

Curity **OSTIC CRINOLINE**

Canadian Hospital Council Holds Successful Meeting

AGAIN the biennial meeting of the Canadian Hospital Council has come and gone, and again a distinct milestone of progress has been achieved. The attendance was excellent, and all of the twelve hospital associations and most of the governments were represented. In addition there was a large gallery of guests including many leaders and well-known figures in the hospital, nursing, medical and public health fields. A tremendous amount of business was presented to the delegates, and it speaks well for the ability and co-operation of the delegates and the leadership of the president that the agenda was finally completed on time. Undoubtedly, with so many vital problems confronting the hospital field to-day, it will be necessary to extend future conferences to at least a three-day period.

A synopsis of some of the reports presented appears elsewhere in these pages, and the full reports will be made available to the hospital field as soon as final revisions will have been completed. In this Journal also will appear the resolutions and a number of the more pertinent motions passed. The full transactions of the meeting will be issued in booklet form at a later date.

Basis of Accounting Approved

One of the major achievements of the meeting was the acceptance by the Council of the forms recommended for use throughout Canada in order to develop uniform methods of accounting and the tabulation of statistics. It is strongly hoped that the joint efforts of the joint committee of the Canadian Hospital Council and of the Dominion Bureau of Statistics will succeed in bringing some order out of our present badly disjointed and nullifying arrangements. Mr. C. J. Telfer, of the Ontario Department of Health, made a strong plea for the synchronization of the hospital fiscal years in the different provinces.

Nursing

The excellent report on nursing developments affecting hospitals, prepared by Sister St. Elizabeth, of London, and her committee, led to much discussion. Miss Gertrude Bennett, of the Ottawa Civic Hospital, considered the eight-hour day for nurses. The new curriculum was discussed, although all to briefly, and Dr. R. T. Washburn, of Edmonton, made strong representation for greater efforts to control tuberculosis in the nursing profession.

Health Insurance

Health insurance discussions were led by Mr. Percy Ward, of Vancouver, and Dr. J. H. Holbrook, of Hamilton, the latter urging the development of better diagnostic facilities with the hospital as the focus point of the plan. Newer developments in group hospitalization were reviewed by various speakers, Dr. A. F. Anderson, of Edmonton, analyzing the excellent progress made by the city-wide plan in Edmonton.

Hospital Finance and Contracts

The debate on this subject was led by Mr. Fraser Armstrong, of Kingston; Dr. S. R. D. Hewitt, of St. John; Dr. G. S. Williams and Dr. George F. Stephens, of Winnipeg, and Mr. Gordon Friesen, of Saskatoon. The establishment of labor unions in hospitals was taken up by Mr. A. J. Swanson, of Toronto, who advocated the open door of negotiation.

Mr. B. Evan Parry strongly urged a general revision of building restrictions in the light of new materials and modern methods of construction.

Other speakers included the Rev. H. G. Wright, who spoke on the problems of small hospitals; Mr. Leonard Shaw, who reviewed the work of the Canadian Hospital Journal; Dr. K. G. Gray, solicitor for the Ontario Department of Health, and Mr. L. D. Currie, M.P.P., reviewed the new legislation; Mr. James C. Brady, Dominion Bureau of Statistics; Mrs. Margaret Rhynas, President of the Ontario Hospitals Aids' Association; Dr. F. W. Routley; Mr. Nixon, of the Department of Transport, who reviewed the proposed regulations respecting radio interference by physiotherapy apparatus; Dr. W. H. Delaney, who spoke on public relations; Rev. Father Burns, Halifax; Dr. John C. Mackenzie and Mr. J. H. Roy of Montreal; Rev. Sister Kenny, Chatham, N.B.; Rev. Father d'Orsonnens and Rev. Sister Allaire of Montreal; Dr. A. K. Haywood and Mr. Oliver Phillips of Vancouver; Prof. Beadouin, University of Montreal, and many others.

In his report the Secretary-Treasurer reviewed the increasing activities of the Council and the urgent necessity that some action be taken at once to increase the financial support of the Council so that its valuable work would not be curtailed. A special committee under the Chairmanship of Mr. Fraser Armstrong was appointed to work out a basis for increased financial support. This matter was later left in the hands of the Executive Committee for further development of this study.

New Officers

Honorary President: Hon. C. G. Power, Minister of Pensions and National Health, Ottawa.

Honorary Vice-President: F. W. Routley, M.D., Secretary, Red Cross Society, Toronto.

President: Rev. Geo. Verreault, O.M.I., Auditor, Ottawa General Hospital.

1st Vice-President: Geo. F. Stephens, M.D., Superintendent, Winnipeg General Hospital.

2nd Vice-President: Rev. H. G. Wright, Sec. Inverness County Memorial Hospital, Inverness, N.S.

Secretary-Treasurer: Harvey Agnew, M.D., Secretary, Department of Hospital Service, The Canadian Medical Association, 184 College St., Toronto.

MEMBERS OF EXECUTIVE COMMITTEE

A. F. Anderson, M.D., Superintendent, Royal Alexandra Hospital, Edmonton.

A. K. Haywood, M.D., Superintendent, Vancouver General Hospital.

Report of the Secretary of the Canadian Hospital Council

Ottawa, September 8-9, 1937

Mr. Chairman and Delegates:

TO-DAY the Canadian Hospital Council is opening its fourth biennial session and, in the interval since its organization in 1931, the Council would seem to have well justified the belief of those who felt that there was a real need for such an organization as this in Canada. In the interval since our last meeting, the work of the Council has shown a steady growth, and requests for service have been received in increasing numbers. Many matters are now being referred to the Council by governments and other interested bodies or organizations. Bulletin No. 20, being a suggested Hospital Pharmacopœia for the use of hospitals, has been issued in the interim since our last meeting and has been much appreciated by the hospital field.

Executive Committee Sessions

The Executive Committee has had two winter sessions (in 1936 and 1937) for the conduct of necessary business, and we are indeed grateful to its members who have travelled long distances under winter conditions to give this service to the Council.

Hospitals are faced to-day with many serious problems, and it is hoped that much constructive discussion will centre upon these at this meeting. Hospital finance is an ever-serious worry, as standards of service and operating costs steadily arise, as the load of non-pay or part-pay patients increases rather than decreases, and as municipalities and governments find it ever more difficult to contribute adequately for the free service given.

Philanthropy is unable and, in many instances, unwilling to carry the burden. In this period of social and economic transition, when we are adjusting the balance of the load between voluntary and state activities, the hospitals (and that means the sick public) are apt to suffer in various ways—inadequate financial support both for maintenance and for expansion, deflection or loss of private or individual interest, loss of autonomy or the impetus for initiative, hampering rather than enabling legislation, outside control by large voluntary organizations, labour unrest and disturbance in morale in the medical and nursing professions. Undoubtedly, these difficulties must eventually right themselves under any social system, for hospitals, doctors and nurses are fundamental to the social welfare, but it is for us at these conferences to discuss and establish those policies which will most efficiently maintain our services to the sick public.

"The Canadian Hospital"

Since April, 1936, *The Canadian Hospital* has been under the editorial and news direction of the Council. You have all noted, I am sure, the change in cover, the wider range and importance of articles and the many new features incorporated. Credit for this is due to our energetic and talented editor, Mr. Leonard Shaw of Saskatoon, who has given unstintingly of his personal services and has been a real insipration to the rest of us. Mr. C. A. Edwards, the publisher, has given us the utmost co-operation in every way, as have also our printers, the Fullerton Publishing Company, Ltd.

In comparison with certain other hospital magazines, this effort may appear small. It must be borne in mind, however, that our potential contributors of articles are comparatively few in number; of more significance, our field of revenue from advertisers is distinctly limited. Our agreement with Mr. Edwards, which was the only fair one in view of the fact that we could not make a cash payment for rights or option, limits reading matter to the same total space as advertising matter. Each month we have far more material ready than can go in, and it is an evidence of Mr. Edwards' spirit that, in nearly every issue, our quota of space has been exceeded. If every one of you would help to get more advertising, the size and scope of the magazine could be still further increased.

By the agreement made last year, the Council has the option of taking over the magazine entirely in 1941, or later, on very favourable terms.

Incorporation and the Constitution

As a result of this agreement with *The Canadian Hospital,* it became necessary for us to incorporate. This was done under instructions from the Executive Committee, in whose hands the whole matter had been left by this Council at the 1935 meeting, and Letters Patent (Federal) were obtained last year.

When application was made for incorporation, our local adviser informed us that it would be necessary to make certain changes in our Constitution to meet Departmental requirements. This put your Executive Committee in a difficult position for we could not legally *change* the Constitution between sessions of Council, and it was imperative that incorporation be made forthwith as we were under agreement to take over the magazine by a certain date. It was agreed by our legal adviser, Mr. Stanley Schatz, and by Mr. J. M. Coady, of Vancouver, who had been advising the Executive on legal points, that the Executive should follow the recognized procedure for such situations (apparently it is of frequent occurrence) and have its officers make application for the formation of a new incorporated body, in this case the Canadian Hospital Council (Inc.); with the consent of the Executive Committee, this was done by the President, the immediate Past President and the Secretary-Treasurer. These three applicants, when Letters Patent were issued, named the old Excutive Committee members to the new Executive and, as you know, wrote to all of the active and associate members formally asking them to affirm membership in the new body and name delegates. This has been done by all of the governments, all of the hospital associations but the Quebec Conference of the Catholic Hospital Asso-

ciation, and by the Department of Hospital Service of the Canadian Medical Association. This procedure permits revision in the Constitution, when delay is inadvisable or the calling of a general meeting impossible.

The present situation is this: we are meeting to-day under the Constitution of the *unincorporated* Council. The Council still functions under the old Constitution, except with respect to the Journal, the contract with which is made through the incorporated Council. You will be asked to ratify the action of your Executive Committee respecting incorporation and to approve the transfer of all assets, goodwill, etc., to the *incorporated* Canadian Hospital Council at this meeting. You will be asked to approve the new Constitution, as prepared by the Executive Committee and approved by the Constitution Committee. This, you will have noted, preserves the objectives of the old Constitution and all of the essential features of our present setup. Any changes made by your Executive are of a distinctly minor nature only.

Changes can be made in the new Constitution, at this time if you so desire, provided such meet with the approval of the Secretary of State. Major changes, however, cannot be made without the usual six weeks' notice.

At this meeting, as at other sessions, committee study reports will be presented. To those who have contributed so earnestly to these fine studies, the Council is deeply grateful. These and previous reports make a most valuable addition to our Canadian hospital literature.

One cannot refrain from drawing to your attention, however, that there is a real danger that this very desirable feature of our work—one of the most valuable—will have to be discontinued. Several of the Committees have not been very active; in certain others everything, apparently, has been left to the chairmen. Some of these studies require steady work throughout the two-year interval—not a last minute compilation of odd notes. The Executive Committee has found a reluctance on the part of some to assume committee responsibility; moreover, there is a distinct limitation to the amount of work which can be left to the Secretarial office either to suggest or stimulate studies, or to complete them. With other routine duties, the Secretary cannot continue to contribute so much time and thought to this work at the expense of his regular responsibilities.

The International Hospital Association

The Fifth World Congress of the International Hospital Association was held in Paris in July, and it was the privilege of Rev. Father Verreault and your Secretary, who were present, to convey the greetings of this Council to the International Hospital Association on that occasion. There were registered some 650 delegates representing 36 countries. An extensive programme was arranged, and many excellent contributions were made. Paris has recently embarked upon an extensive programme of hospital construction, and we particularly enjoyed the opportunity to inspect the new Cancer Hospital, the Foch Foundation at Neuilly and the magnificent new Beaujon Hospital at Clichy, a municipal institution where they actually have a fully equipped creche building for the fairly numerous babies of the nurses.

Of particular interest to this body is the decision of the International Hospital Association to meet in Canada in 1939. The meeting will be held in Toronto in conjunction with the convention of the American Hospital Association, and the eight or ten other associations which always meet concurrently with it. It will be in all probability the desire of the Canadian Hospital Council to arrange its 1939 meeting to coincide with this extraordinary meeting, which promises to be the greatest hospital gathering ever held in Canada. The International Hospital Association is coming on the joint invitation of the American Hospital Association and the Canadian Hospital Council.

Naturally, this is a tremendous undertaking, particularly for the various committees, but also from the viewpoint of finance and of programme. It will be most essential that everybody do all that can be done to make this 1939 meeting a noteworthy one and a credit to Canada. We shall particularly require the assistance of our French-speaking confrères both on the proposed arrival via the St. Lawrence route and at the meeting.

Re-Organization of American Hospital Association

The proposed new Constitution for the American Hospital Association, which will come up for adoption in Atlantic City next week, is of interest to the Council. This body, which is "American" in the broader sense and includes most of our leading Canadian hospitals in its membership, is now governed by a Board of Trustees responsible to the General Assembly. It is proposed, and very logically, that there be set up a House of Delegates, properly representing all parts of the United States and Canada, which would be the legislative body and which would elect the Board of Trustees, and the Officers of the Association. The Trustees, in turn, would be the executive body, as now. Among other changes there will be a revision in the basis of membership and a more equitable basis for determining annual dues.

By the new Constitution of the American Hospital Association the members in each province will be entitled to name at least one delegate to the House of Delegates—possibly more, if they have a large membership. The suggestion has been made that the Canadian Hospital Council might name the Canadian members of the House of Delegates, but, as these are to be named by the American Hospital Association members in each province, that does not seem possible.

For some hospitals the new scale of dues may raise the annual cost of membership—for the majority there will be no increase, possibly a reduction. Undoubtedly, membership is worth more than it costs, although it has been suggested that Canadian hospitals, with somewhat lessened benefits, should pay lower dues.

No major changes have been made since our last meeting, but several minor changes and a number of clarifying interpretations have been made. On the whole these have been favourable to the hospital field. A review of the more recent revisions appears in the Report of the Committee on Legislation.

On behalf of the Executive Committee your Secretary desires to express their appreciation of the loyal support of the whole hospital field, the highly valuable participation of the governments and the enthusiastic support of so many delegates and other hospital workers.

All of which is respectfully submitted,

HARVEY AGNEW,
Secretary.

Report of the Editorial Board of the "Canadian Hospital"

By LEONARD SHAW, B.Sc., Editor

Mr. President and Members of The Canadian Hospital Council:

IT would seem desirable that your Editorial Board report at this time on their work in connection with the official Journal of the Council, "The Canadian Hospital."

At the risk of prolonging the report by quoting figures it is felt that such quotations are necessary to more clearly advise the Council relative to the work accomplished and so a compilation has been made covering seventeen consecutive issues of the Journal commencing with the April issue of 1936 and including the August issue of 1937. Only in special instances has a classification of articles been attempted.

General articles	151	Av. 8.8 per issue
Editorials (Obiter Dicta)	54	Av. 3.2 per issue
Photographs	126	Av. 7.4 per issue
Canadian Dietetic Ass'n articles	31	Av. 1.8 per issue
Symposia	2	
Articles in French	7	
Answers to questions (We Would Like To Know)	133	Av. 8 per issue
News of hospitals including Hospital Construction (Here and There in the Hospital Field)	191	Av. 11 per issue
Fillers, including short articles	254	Av. 15 per issue
Ontario Hospital Association News	6	
Book Reviews	12	

For the twelve issues from April, 1935, to March, 1936, the total number of pages printed were 476 or an average of 39.5 per issue. For the year, April, 1936 to March, 1937, 542 pages were printed or an average of 45.1, an increase during our first year of 5.6 pages per issue compared with the previous year, or approximately twelve per cent. During the seventeen months 644 letters were written or an average of 38 per month.

As Council is no doubt aware the agreement with Mr. Edwards is that there should be one page of manuscript material for each page of advertising. We extend our sincere thanks to Mr. Edwards in that for almost every issue he has allowed us to exceed our quota, in some instances to the extent of several pages. This generosity on his part and the wonderful spirit of co-operation he has shown towards the Editorial Board leaves us deeply indebted to him.

At the time of taking over the Journal a contract was in existence which covered advertising on the cover page. This contract did not expire until October, 1936, and on the November issue we were able to publish for the first time a permanent cover design, the idea for which was probably created at an impromptu meeting of the Editorial Board held in Cleveland during the American Hospital Association Convention, but credit for the final design must go to Messers Govan, Ferguson and Lindsay, who generously created and sketched the modern hospital we now see each month. A colour scheme for the cover has not yet been decided upon and the matter could profitably be discussed at this meeting. Since November, 1936, we have run a multitude of colours in the hope that one would merit sufficient general appeal that it could be officially adopted, although it must be admitted that changing the colour from month to month has a certain amount of value also. We sincerely hope that the design and general appearance of the cover meets with the approval of the Council.

When first assuming duties the Editorial Board hoped that it would be possible to procure French translations of the more important articles but regretably it was found that such translations were too time-taking for those who were willing to attempt them and the idea had to be discarded for the time being. Perhaps some arrangements can be made during the meeting now in session to re-establish this policy. We express our thanks to Rev. Father Verreault for the translations made by him and at his direction.

Although the present Editorial Board would seem to be relatively complete, both the Executive of the Council and the Board itself have felt for some time that a lady member to the Board would be a tremendous acquisition and it is hoped that such member be added to the existing personnel.

We trust that the general articles which have been published meet with your approval. Considerable care has been exercised in their selection and we have endeavoured in the short time we have functioned to give a fairly representative cross-section of hospital administrative problems. Practically every departmental activity to be found in hospital work has been covered although, of course, certain subjects have been more easily obtained than others. We feel that more articles on maintenance problems should have been available but regretably we found a great deal of hesitancy on the part of people who are qualified to write on this subject. We could, no doubt, have turned to various experts in the commercial field but have felt a little reluctant to take such a step until we are sure that the hospital field itself has been properly canvassed. Because of the national scope of our Journal we have endeavoured to consider the geographical point of view as much as possible when selecting our writers, giving, of course, proper consideration to their qualifications but despite all planning it has been necessary to obtain last minute articles from the vicinity of the Editor's office.

Our editorial page perhaps has not been as forcefully written as it could have been but it has been felt that a moderate policy should be adopted. We have tried whenever possible to bring the editorials to a specific conclusion thereby presenting a true editorial opinion rather than leave the solution to the reader. Perhaps as we grow older it will seem provident that we should emphasize Council policy to a much greater extent.

The question and answer page, "We Would Like To Know", seems very popular and the majority of questions

which have been answered were received from individual hospitals. Some of the questions, however, have been taken from current round table discussions at various meetings. In every case where an answer has been given we have endeavoured to be as helpful and as practical as possible. A considerable number of questions received seemed unsuitable for publication but these have been answered directly and in passing we might say that three such questions called for the preparation of plans for additions to buildings. Where it seemed that the question had reasonable urgency a written answer was given to the enquirer without waiting for publication and such question was then published in a subsequent issue if it seemed to be of sufficient interest to the field at large. Only two exceptions have been taken to our answers, one being a commercial institution on the occasion when we, in their opinion, used a trade name in describing a product. Although we are still of the opinion that the misinterpretation was theirs, an apology was given both in the Journal and by letter, and accepted. The second instance was a nursing problem which brought forth friendly and constructive discussion between "The Canadian Nurse" and ourselves.

At the beginning of the year an invitation was sent to all provincial hospital associations offering them space in the Journal at a rate of $10 per page for their own association news. Whereas the Journal is happy to receive news from the associations that is of general interest to the hospital field it was felt that from time to time the associations would have items which would be limited in interest to their own members and that through the pages of the Journal they would find an economical and interesting way to present such news. This offer has been accepted to a limited extent and in the case of the Ontario Hospital Association a complete page, and Alberta Hospital Association part of a page, is published monthly. Similar offers have been made also to organizations allied to the hospital field but to the present time no acceptances have been received.

As far as the future policy of the Journal is concerned very little can be said. We believe that we have a fairly clear conception of the wishes of Council and we are certain that sufficient material will always be available regardless of the size of the publication, in fact, our biggest problem at the present time is that of limited space. This condition, of course, is dependent purely upon the amount of advertising but we feel and hope that our advertisers are becoming more interested in the Journal and that in the future their support will be greater. In this matter it may be said that the hospitals themselves can contribute to the interest that the advertisers have in us by letting such advertisers know that offerings are looked for and read in the Journal. We feel that members of the Council in session here have many valuable suggestions that will enable us to more intelligently interpret their wishes and we hope that a very frank discussion takes place for when all is said and done as the mouthpiece of the Council we are dependent upon you for our policy. We hope our activities to date will meet with approval by the Council and that our shortcomings will be overlooked.

This report would be far from complete without expressing our deep appreciation to Dr. G. Harvey Agnew and his secretary, Miss Anne McLachlan, for their constant assistance. Every month they have made available valuable material and have spared no effort in aiding the Journal to achieve whatever little success it has achieved. We are deeply appreciative of what they have done and wish to put ourselves on record accordingly.

It goes without saying that we are greatly indebted to the Publication Committee for their valuable assistance and to all who have written articles, in the case of the latter group we have endeavoured to acknowledge our appreciation by individual letters as articles have been received.

Respectfully submitted,

Harvey Agnew, M.D., Toronto;
R. Fraser Armstrong, B.Sc., Superintendent, Kingston General Hospital;
A. K. Haywood, M.D., Superintendent, Vancouver General Hospital;
S. R. D. Hewitt, M.D., Superintendent, Saint John General Hospital.
J. C. Mackenzie, M.D., Superintendent, Montreal General Hospital.
H. A. Rowland, Phm.B., Superintendent, Riverdale Isolation Hospital, Toronto.
Rev. Geo. Verreault, O.M.I., Ottawa.
Leonard Shaw, B.Sc., Superintendent, Saskatoon City Hospital.

Hospital Costs

The following recommendations are made by the Committee on Medical Relations of the Canadian Hospital Council (with kind permission of the Ontario Medical Association). "We suggest that hospitals are sometimes too palatial, and equipment too elaborate. There should be provided in every large community one or more separate convalescent or rest-home wings or branches which could be carried on at a much lower cost than that of the hospital proper.

The patient should be constrained to enter the class of ward which he can afford.

The medical staff should exercise discretion in prescribing only those medical investigations which are really indicated.

Small hospitals should not attempt diagnostic and therapeutic procedures for which skilled personnel is not available.

In the management, the greatest economy should be exercised, with special attention paid to linens, food stuffs, medical supplies and the incinerator.

Payment to student nurses should be reduced at least, on the ground that in no other profession are apprentices given room and board. This course would entail the abolitin of any other labour by student nurses than that required in the course of learning their profession.

The use of graduate nurses in smaller hospitals in place of student nurses, flat rates for hospital services, deferred payment plan, group nursing, collective buying, and part-time specialist services, are other means of reducing costs where circumstances warrant, and should be investigated.

HOSPITAL CONTRACTS

Report of the Committee on Hospital Contracts of the Canadian Hospital Council, Ottawa, 1937

By JAS. H. McVETY, ESQ., Chairman

HOSPITAL contracts may be divided into two groups—(1) those covering the purchase of materials and the employment of labor, technical and scientific knowledge, and (2) those governing the disposition or sale of the service resulting from the use, blending and refinement of the components comprising the first group. In the purchase of essentials hospitals generally follow the same rules as other businesses. They buy in the open market and the results obtained, in the main, compare favorably with those of the most capably administered corporations and industries. Methods change, but the hospitals keep well abreast of the times in this branch of their activities, the competitive factors assisting materially in this respect.

This report forcefully points out two forms of contract practice involving the hospital field and offers remedies which may be adopted with advantage to meet any local situation.

It is in the second group, the sale of hospital services, that the most unsatisfactory situation exists. The late Grant Hall, Vice-President of the Canadian Pacific Railway, once described the operation of his company: "We buy labor and materials and we sell transportation." To a suggestion that labor and materials were bought in the cheapest market and the transportation was sold for all the traffic would bear, he observed: 'That is putting it very frankly." It will be readily seen that hospitals are in a very different category to railways or other industries insofar as the disposition of their services is concerned. Owned and operated by municipalities, community-owned corporations, church organizations and religious orders and never expecting to pay a dividend they are a curious combination of business administration and of service provided free or only partially paid for by recipients.

Development of Present Situation

A study of the early history of hospitals is essential to an understanding of how they have reached their present involved relationship to the communities they serve. Originally started by religious orders, as places of refuge for persons requiring shelter or unable to care for themselves, the services rendered were free, but the recipients were encouraged to give alms to help perpetuate the institutions for those who would later require care. Compared with even the poorest equipped modern hospitals, the earlier efforts must have been confined largely to the provision of food and lodging. Recently a ceremony commemorating the seventy-fifth anniversary of a Western hospital was attended and one had an opportunity of examining the early records. The methods of treatment were most primitive, and judging by the pharmacy accounts, rye whiskey and port wine were important items in the pharmacopœia of the day. Appeals for aid were printed in four languages and met with about the same response as similar efforts in our time. Operating expenses were relatively low, but the services were of the same order. To appreciate how little equipment was available one has only to list the apparatus and methods that have come into use during the past thirty years in hospitals.

Inventions, scientific research, modern technique and greatly improved educational facilities and standards of living have made hospitals into scientific and practical health centers for the treatment and prevention of disease. Concurrently, expenses have risen. The demand for improved services is far ahead of the willingness and ability of the citizens to pay. Local pride causes the construction of hospitals in areas well served by existing institutions situated some distance away, but easily reached by modern methods of transportation. There is a definite trend, particularly in the West, towards State maintenance of general hospitals in addition to those for the treatment of mental and venereal disease and tuberculosis. The maintenance and operation of hospitals by private endowment is no longer possible. The State, either Dominion, Provincial or Municipal, is being called upon to bear a larger share of the cost of combatting disease both in hospitals and in the field of public health.

The modern hospital is no longer able to rely on voluntary subscriptions or to provide service on the basis of the popular conception of what it is worth. Persons who pay from three to ten dollars per day for hotel accommodation complain bitterly if charged comparable amounts for greater and much more inclusive service in hospitals. Governments provide grants in aids and branches of the same governments expect hospitals to care for patients for which they are responsible at arbitrarily fixed rates far below the cost of the services.

Different rates are paid hospitals for exactly the same service, the trend being to take advantage of every opportunity to create and maintain competition between hospitals for the business.

Compensation Boards, in provinces where government grants are computed on a patient day basis, expect this allowance to be credited to Compensation Board patients or allowed for in fixing the amount to be paid by the Board. Associations of doctors, workmen, fraternal or-

ganizations and others drive hard bargains for hospital care for their members or where they have contracted to provide hospital service and medical care. The result is that hospitals all over Canada are accepting contracts at less than cost, and in some cases at a loss of at least twenty-five per cent. A distinction must be drawn, of course, between branches of government which enforce an arbitrarily fixed rate and organizations which make contracts, which, although improvident, are accepted by the hospitals. The blame in the latter case is the responsibility of the hospitals concerned.

Basic Causes

A search for the causes and remedies points rather definitely to the fact that the *hospitals are almost entirely responsible for the existing situation.* Altogether too few have adoped the standard system of accounting and statistics adopted by the Canadian Hospital Council and the Dominion Bureau of Statistics, two years ago. Many hospitals are not able to determine their cost of operation either for general or auxiliary hospital service. Too many operate on the theory that any return obtained by filling an empty bed is profit. Receipts are considered in the aggregate instead of being credited to the cost of the service for which they received. Competition between hospitals in local areas is another common cause of improvident contracts.

The Remedy

The remedies appear reasonably easy to apply.

(1) The most important is to adopt a *system of accounting* that will permit of costs being accurately determined.

(2) Require pay patients to pay the *actual cost* and a reasonable profit (to help meet cost of charity service) for the service provided.

(3) Credit grants from governments and municipalities to *the cost of indigent patients,* the purpose for which the grants are made.

(4) Organize *local advisory councils* to consider and approve all contracts and make each contract apply to every hospital represented in the council.

(5) For hospitals in isolated areas the provincial hospital associations should appoint a *contract committee* and affiliated hospitals should agree to submit all contract proposals to this committee for consideration and approval.

(6) Governmental departments and Compensation Boards should be required to pay *full cost* of their patients, and the basis of payment should be submitted to the local or provincial contract committees.

(7) *Abuses* such as deducting from hospital accounts for treatment ordered by attending physicians and held to be unnecessary by departments or boards months afterwards should be definitely dealt with by the local or provincial committees or the associations.

(8) In a country such as Canada, covering such an enormous area and with greatly varying local conditions, it is impossible to deal with local problems, except insofar as they can be covered by general prinicples. This study, therefore, deals only with general causes of complaint and recommendations for the application of remedies which are capable of adjustment necessary to meet any local situation.

To those of my colleagues on the Committee, who have assisted by letters and articles portraying many angles of the problems, my sincere thanks.

Record Keeping in the Small Hospital *

By Anne E. McLachlan, R.R.L.,
Canadian Hospital Council.

In the article "Record Keeping in Hospitals, Large and Small", which appeared in the April, 1937, issue of *The Canadian Hospital,* some of the reasons for good records were outlined in a general way, and some of the difficulties encountered in organization. Our small hospitals, however—and the great majority of our hospitals are under 75 beds—have their own *special problems.* Solutions for a few of these problems are suggested herewith.

One of the requirements of the accepted minimum standard is "that accurate and complete case records be written for all patients and filed in an accessible manner in the hospital . . . a complete case record being one which, except in an emergency, includes the personal history; the physical examination with clinical, pathologic and X-ray findings, when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge and, in case of death, the autopsy findings, when available."

Importance of Records

Every patient has a right to the best that local medical, surgical and hospital care can offer. The doctor who has lost interest in study is not the one who holds the confidence of an institution or a community. The average doctor does not think it necessary to give much of his time to writing records, which he frequently thinks are superfluous. Yet, let me cite one instance to show how important the record of a previous patient is in the case of the death of a doctor. Minnie Genevieve Morse in her booklet "Case Records in Small Hospitals," relates the following incident:—"In a hospital known to the writer, a patient was recently admitted who had some years before undergone in the same institution a major operation, the character of which she did not know. The surgeon who had performed the operation was dead. The doctor under whose care she now was, and who had no personal knowledge of her previous history, at once demanded the record of her earlier admission. It was found, after some difficulty, as it bore only the patient's surname, but it showed neither history, physical examination, nor diagnosis, while the operating-room sheet gave nothing but the names of the surgeons. What the lack of the information the record should have contained may mean to the patient, no one will ever know.

"Again, a patient may go to a hospital or consult a physician in another city, and a request may be sent to the hospital in which he was formerly treated for an account of his condition and treatment at that time. If the information is not forthcoming, the patient again is the loser."

*The Canadian Hospital, Vol. 13: 5, pages 29-33, May, 1936.

Tuberculosis in the Nursing Profession

Report of the Committee on Research to the Canadian Hospital Council, Ottawa, 1937

By R. T. WASHBURN, M.D., Chairman

JUDGING by the vast amount of literature written during the last few years on the subject, "Tuberculosis in the Nursing Profession," it is evident that all associated with the welfare of the nurse are alive to their responsibilities of doing everything possible to lessen the incidence of the disease. We are indebted to Drs. Geo. Ferguson, E. L. Ross, J. H. Holbrook, R. J. Collins, the late David A. Stewart and other outstanding men for bringing it home by their writings so forcibly to those occupying provincial health offices that we now have regulations governing approved hospitals setting out certain procedures in regard to the periodical examination of nurses. We are especially pleased to learn of the recent action taken by the Canadian Tuberculosis Association in deciding to carry out, during the next few years, a more or less uniform program study of tuberculosis among nurses in training. The object is to find out, if possible, whether the tuberculosis risk in hospitals is greater to those who enter service as non-reactors to tuberculin than to those whose reactions are positive, and whether those negative reactors whose reactions are positive, and whether those negative reactors whose reactions subsequently become positive, show evidence of a definite lesion.

Canadian Tuberculosis Association Plan

The plan proposed is as follows:—All nurses, both graduate and undergraduate now in hospitals, will be tested with tuberculin immediately, and all pupil nurses will be tested within two or three weeks of entering hospital. All non-reactors will be re-tested every three months until such time, if ever, that they react. When a non-reactor becomes positive, showing, as we believe, evidence of recent tuberculosis infection, the chest will be X-rayed for a possible new lesion. Those nurses who become reactors while in training will be watched very closely.

This move on the part of the Canadian Tuberculosis Association, providing that it meets with the full support of all hospitals, is a real step forward. Even if the morbidity of the disease may not be affected, undoubtedly the plan will enable all hospitals to spot the disease sufficiently early to commence treatment in time to reduce the mortality from tuberculosis among institutional nurses to practically nil. We do know that many hospitals are now carrying out this procedure as routine, but if every hospital in Canada, which operates a training school, will supply its findings to a Committee of the Association, greater interest will be taken by the hospitals themselves. In addition the Committee will be encouraged to carry out further consideration to the advisability of immunization when it is shown, without a shadow of a doubt, that positive reactors stand the strain of nursing better than negatives.

Now that we are well on our way in doing everything possible to spot tuberculosis early and offer early treatment which will greatly lower the mortality, we must turn to the root of the evil as here much more must be done in preventing nurses from being infected. We are satisfied that more can be done by hospitals to meet this problem. The problem may be divided into two main categories: firstly, inadequate early training of the nurse in the knowledge of tuberculosis and the methods of protecting herself from infections; and secondly, the necessity of a greater care being taken in spotting unrecognized tuberculosis patients when they are being admitted to the general or other hospital.

Education of the Nurse

Regarding the former, a Medical Superintendent of a reputable Sanatorium, speaking of nurses trained in a general hospital affiliated with his institution, said, "They have no idea of protecting themselves from infection nor of preventing the spread of the disease; in fact, their knowledge is deplorable . . . If the entire nursing profession really understood the problems of tuberculosis and acted intelligently they could be a considerable asset in the prevention of the spread of the disease." These are strong words and many nursing schools will probably resent such a statement, but one is bound to support him in his contention. Let us take for example the probationer. A girl enters the training school with little or no knowledge of infections and protective measures and in two or three weeks she is making patient's beds on the wards. How can she possibly have the knowledge to properly care for herself and have cultivated her powers of observation in order to recognize breaches of technique, against which it is presumed the patient has been warned by more experienced nurses. More thought might be given to "the knowledge of communicable disease technique" by training school executives, in setting out the course of instruction during the probation period preparatory to the nurse coming in contact with patients. In fact by an adjustment of the curriculum I feel that a year's successful instruction can be given in the classrooms before the nurse enters the wards.

The Unrecognized Case

Regarding the second factor, that of greater care being taken in spotting unrecognized cases of tuberculosis on admission, over-specialization may be considered as one of the reasons why patients are admitted to the general wards with concurrent tuberculosis. In this age of specialization too much attention is paid to the disability coming within the specialty and not enough to the patient's general condition, and as such there is a greater possibility of tuberculosis being overlooked. Our out-patient departments, for instance, examine two or three hundred patients in a few hours. Of this number there is a percentage requiring hospitalization. They are sent in for admission and distributed to various medical, surgical, obstetrical and gynaecological services. We realize that many of these cases

coming under the specialties have not been thoroughly examined. Even a careful clinical examination of the chest in many instances will not demonstrate the presence of tuberculosis without the aid of the X-ray. Unless there is a chest service established in our hospitals by which everyone to be admitted is thoroughly examined for the possibility of tuberculosis, we are bound to have unsuspected tuberculosis brought into the wards. It may take a second only for a nurse to become infected and, unless the chest examination be made prior to the patient going to the wards and all suspects X-rayed before the nurse comes in contact with the patient, there is a danger of her being infected. It might be well for all hospitals to consider a plan of having a chest service with possibly, if the hospital be large enough, a resident with sufficient training to recognize the necessity of an X-ray of the chest. As an alternative every patient admitted could be placed on precautions until a clearance is given by the attending physician that the patient is free from any infective tuberculosis. Naturally these precautions would require additional work and would probably cost some money.

The situation as it stands to-day is that in spite of the greater care being taken in guarding our nurses against the infection of tuberculosis they are continuing to contract the disease. We must not be content with regulations governing skin tests and the frequent use of the X-ray, but must promulgate such preventive procedures as will give the nurse in her early training a better understanding of tuberculosis and the methods of preventing infection and must also, through staff organization, be certain there is no undiagnosed case of tuberculosis on the wards.

La Tuberculose Chez les Gardes-Malades

Par Soeur Valérie, Hôpital Ste-Justine, Montréal.

Toutes nos gardes-malades ont un examen médical complet dès leur entrée à l'école, y compris une radiographie des poumons, un examen d'urine et une analyse de sang.

Rapport est fait par écrit et si le médecin trouve qu'un autre examen serait nécessaire quelques semaines plus tard, avant d'envoyer l'élève en service nous le faisons faire. D'après nos règlements, dès qu'une garde-malade, gradée ou élève, a maigri ou semble tant soit peu fatiguée, le Docteur prescrit le repos nécessaire ce qui est accordé avec la médication prescrite.

Dès les premiers jours de leur entrainement, nous enseignons à nos élèves comment se protéger contre toute infection:

1. En leur montrant comment se comporter auprès des malades. En leur apprenant l'importance d'une désinfection fréquente de leurs mains, surtout lorsqu'elles ont à manipuler les objets du malade.

2. En organisant leur vie de façon à ne pas avoir de surmenage, les encourageant à profiter des heures de repos qui leur sont accordées, surtout les heures de sommeil, (nous exigeons que nos gardes-malades restent au moins 8 heures dans leur chambre lorsqu'elles sont en devoir de nuit) leur montrant la nécessité de s'alimenter substantiellement et de ne pas sacrifier le temps du repos à une sortie; au besoin la surveillante du service donne un supplément entre les repas.

NEW TRAILS

By Hugh Stuart, *M.D., Calgary.*

My early days in Baffin Land are replete with homely illustrations, which the intervening years have failed to dim. The title is suggested by one of these northern scenes, commonplace but beautiful.

It is pitch dark, about three in the afternoon, and the sky is overcast so that the headlands skirting the sea-ice are difficult to see. The "going" is bad and the dogs are tired. The trail is new and leads among islands where the swift currents scour the ice away to treacherous thinness. It is unsafe to walk, so Avoonik and I sit on the komatik. He jabs intermittently through the snow at the ice beneath, endeavouring to estimate its thickness and quality. Suddenly from behind appears a brilliant phosphorescent outline of the dog-tracks and komatik runners. Bright as the glow from a radium dial is this refulgent beauty in the darkness. It is not without a further significance, however, for it is a warning that the underlying ice is overlain with sea water. With sharp cries of "Ouogga! Ouogga!" to the dogs, we turn more landwards and soon the blackness of the night remains no longer illuminated by this entrancing phenomenon. Far behind, the glowing trail remains a testament to our successful passage in dangerous places.

And so often are such transient exhibitions of beauty presented to us only in the bypaths of life. We, in the outlying hospitals, must not keep too close to the landward. Progress and its own inherent beauty will always be accompanied by a certain feeling of insecurity. As Montaigne has aptly said, "There is a coldness to all altitudes." The sense of isolation should be no deterrent to a hospital endeavouring to be in the vanguard.

How often we excuse our inadequacies by indicating the mileage from the "big centre". Let us beware that the intervening distance is not intellectual rather than geographic. The literature is crying out to those of us in the wilderness, if we will but read.

We in the healing art have been left an high estate, but so often do we neglect to keep our house in order. The demands of asepsis are not tempered by geographic location. The bacilli of a 50-bed hospital are just as virulent as those in one of a thousand beds. A cutting edge on an instrument can be maintained in the shadow of the Pole or under the prism lights of the amphitheatre. The old adage is still vigorous: "A workman is known by his tools." So let us keep ever conscious of the impelling necessity for accuracy in details.

The art of medicine is probably given to few, but those of us who have the opportunity to offer instead a modicum of scientific application can be of untold impetus in the small hospital. Our trail is new and the pattern thereof is governed by our endeavours alone. The "going" may be insecure, but the stimulating effect is good for the "torpid liver of complacency", and, as we look backward, the route may have acquired a certain brilliance from our passage.

Extracted from Bulletin No. 25 C.H.C.

A Summary of the Report by the Committee on Hospital Finance

By R. FRASER ARMSTRONG, B.Sc., Chairman

HOSPITAL finance is a broad subject, embracing almost every administrative and hospital service detail. Naturally your committee had to restrict its considerations and decided to confine itself to a discussion of policies and thoughts affecting the worrisome problem of adequate revenues.

During the depression period unskilled hospital workers were content with good board and a small wage; professional workers were glad to enter into special service agreements and equipment and commodities of all kinds were available at depression prices. Now the situation has changed and the cost of providing service to the patient has increased greatly.

This report stresses the desirability of a better equalization of the sources of revenue to hospitals than exists at the present time.

The task facing each and every hospital board is to promote the required gross revenue to cover the cost of a sufficient and adequate patient service. The gross revenue must come from the three following general sources.

1. Fees paid by paying patient.
2. Fees paid by municipalities, governments and governmental agencies.
3. Interest earnings from endowments made possible by private philanthropy.

The only revenue which the hospital itself can regulate is the revenue coming from the private and semi-private patient. This particular group makes up about 40% of the patient population of the average hospital and it is hardly to be expected that this minority group can finance, not only the increased cost of their own service, but in addition, the increased cost of service extended to the 60% majority group. The time has arrived, therefore, when much thoughtful consideration must be given to the gross revenue requirement of a hospital.

Municipalities are having their financial difficulties. The payment of indigent accounts is for them a problem. On the other hand, it is felt that the citizen would welcome a distribution of the burden which would take a load off the paying patient. At present the excessive cost of collecting indigent accounts from those patients whom the municipalities feel should pay is a lost expenditure. Some plan should be arrived at which will reduce this needless expenditure. Instances can be cited where it has cost the hospital much more to collect these accounts than the original charge for the service rendered. This situation has a considerable influence on the net value of the municipal contribution. Our report suggests the promotion of arbitration boards.

Governments and Government agencies may have the opinion that in reducing their fees for various hospital services, they are promoting a citizen economy. But if the service must be given the gross revenue must be obtained and there is no ultimate citizen economy in simply passing an extra burden to the sorely pressed paying patient. This is a point your committee has tried to make and we suggest a group study of fees now being paid by such government organizations.

We believe that private philanthropy has not entered into the picture of hospital revenues to the extent it should and that in order to promote additional revenue from this source the antagonism caused by the feeling "the private patient pays well for any service received" must be removed. This can be accomplished by a program of publicity informing the citizen of the cost of the many "behind the scenes" services extended and by the other revenue groups assuming a more reasonable proportion of the gross hospital cost. It might be to the advantage of the different governments to review their Succession Duty Acts with the hope of encouraging hospital bequests and to co-operate with a hospital group in a publicity campaign setting forth the citizen benefits obtained by increased revenue from endowments. A greater revenue from this source would help, not only the hospital but indirectly the governments and municipalities.

It is hoped that the thoughts expressed in the finance report may assist in creating a public opinion which will support and insist upon a better equalization of the sources of revenue to hospitals than exists at present. If this is the result, then the Committee feels they have done something worth while, not only for the hospitals but for the taxpayers of Canada. It seems a much fairer equalization of the cost of hospitalization to ask the citizen to pay a small annual fee, while well, in the form of a small special tax, than to ask him to pay a higher fee when hospital care is required.

Sick Room Rental Service

The Berkeley General Hospital, Berkeley, California, has inaugurated a nice community service in making available for patients who are sick or convalescing in their homes to rent needed hospital and bedside equipment. The sick room rental service is maintained at the hospital. Among the equipment available for rental are hospital and fracture beds, Balkan and Brandford frames, wheel chairs, invalid walkers, splints, crutches and canes, bedside tables, back rests, and miscellaneous bedside equipment.

—"Hospitals.

Obiter Dicta

Letting George Do It

THE 1937 meeting of the Canadian Hospital Council has come and gone and those fortunate enough to be present have gone home dizzy with the wealth of material and opinions presented. One constructive criticism is suggested. A leading feature of the program is, or should be, the discussion of the valuable reports of the study committee. In many instances this was marred by the inability of the secretarial office to send the reports to the delegates for study before the meeting, due to the fact that the majority of the reports were not received until too late for such desirable procedure. Some were not received at all. Apparently committee chairmen get very dilatory, if any, assistance from their members and this is fatal in a young organization, especially where the number of possible workers, as in Canada, is distinctly limited. If the Council is to continue the excellent pace already set, it will be absolutely essential that everybody get behind it and give it the help which it deserves.

A Big Meeting

It needed but a cursory glance at the agenda of the Fourth Biennial Meeting of the Canadian Hospital Council, held in Ottawa on September 8th and 9th, to make delegates realize that they were in for a very heavy session. However, the majority had attended previous meetings and knew that by hard work and good fellowship that the task could be accomplished. Needless to say the end of the first day found everyone tired out. It would seem in order to constructively suggest at this time that considerable time could be saved if all speakers and debaters would condense their remarks to the very pith of their subjects, keeping in mind that the text will be published in the form of bulletins and proceedings. However, despite the heaviness of the programme, we had a wonderful meeting with a great interchange of ideas, and it goes without saying that delegates when they get all sorted out will be able to give their associates a report of great value.

We congratulate President W. R. Chenoweth on the manner in which the meeting was conducted and in the way he and the Executive have guided the affairs of the Council during the past two years. We extend to the new president, Reverend Father Georges Verreault, O.M.I., our sincerest good wishes during his term of office, for we know he will spare no effort in the interests of the Council, which means the interest of all Canadian hospitals. This issue of "Canadian Hospital" is devoted largely to news from the meeting, and we are sure that after reading the reports our readers will feel that the Canadian Hospital Council is very much alive and doing real work for our hospitals.

L'Assemblée du Conseil Canadien des Hôspitaux à Ottawa

TOUT le long de deux grandes journées bien remplies, le Conseil Canadian des Hôpitaux a discuté à Ottawa, les huit et neuf septembre, des problèmes qui intéressent non seulement les administrateurs des hôpitaux, les médecins et les infirmières mais aussi la grande majorité des citoyens du pays. Dans une atmosphère de coopération et de bonne entente, les délégués apportèrent le plein de leur expérience et de leurs connaissances techniques.

Des médecins, des religieuses, des directeurs laïques d'hôpitaux, des représentants de deux ministères fédéraux et de presque toutes les administrations provinciales ont siégé ensemble, échangeant les vues de l'est contre celles de l'ouest, les désirs des gouvernements contre les points de vue des hôpitaux.

C'était une occasion historique puisque le premier jour, une nouvelle organisation, dont le nom est le Conseil Canadien des Hôpitaux (Incorporé) prenait lieu et place du Conseil Canadien des Hôpitaux qui cessa d'exister au cours de la même séance.

Le grand avantage de ces réunions biennales devient de plus en plus évident à chaque réunion. Déjà on calcule que grâce à notre organisation, les hôpitaux du Canada ont réalisé une épargne de $300,000 et encore ce chiffre n'est -il qu'approximatif. Grâce à ces rencontres beaucoup de problèmes régionaux ont trouvé leur solution longtemps cherchée.

Les rapports qui sont tous imprimés d'avance sous forme d'épreuves typographiques permettent la discussion immédiate. Voila comment on peut en deux jours, faire le travail ordinaire d'une semaine. Il va sans dire que toute la série de ces rapports, qui est ensuite publiée en tracts devrait se trouver dans toutes bibliothèques hospitalières et à la portée de tous ceux qui s'intéressent aux problèmes de l'hospitalisation.

Extracts From the Report of the Committee on Construction and Equipment

By A. J. SWANSON, ESQ., Chairman

BEFORE any building programme is entered upon, whether a new plant, a complete new hospital, or an addition, it cannot be stressed too strongly that the building committee should look well into the future and always have before them the ultimate goal indicated by the complete hospital set up. This is particularly necessary at this time of change. Not only is the type of building changing very rapidly but the whole physical interior of the building, occasioned by demands of modern medical technique, is undergoing constant revolutionary change. As an indication of this we only have to look at the modern laboratory set-up as compared with a laboratory of a decade ago and from all indications it would appear that we are on the threshold of further great changes in this particular.

Your Committee for the past four or five years has been studying various hospital trends in the discussion of these various matters at the conventions, and it is our hope to condense in this report, outstanding changes and endeavour to visualize the changes which may occur in the future. Your Committee has felt it should touch on what seems to be important, and would ask that those interested in any particular phase of construction should communicate with the Secretary of the Canadian Hospital Council, whereupon all possible data relative thereto would be made available.

Lower Hospital Costs Essential

Unquestionably many more of the acutely ill should be cared for in hospitals than are admitted each year, and among the many reasons why this is not done is that of the expense involved. One authority has stated that, if all those who needed hospital care could have it, hospital occupancy would be doubled. The problem for the future is to find radical ways to reduce the national budget—to lower hospital rates, and make hospital service more available to those above the charity level.

Business and industry have devised many expedients for deflating costs aside from cutting the payroll. Hospitals must do likewise. Group hospital insurance where fully organized should contribute substantially to earnings but the hospitals, as a group, must find some methods of lowering their costs substantially and permanently.

There are many serious burdens in the expense column, which we have always more or less taken for granted, but in most large cities some or all of the following money-saving measures can be brought about under the present pressure of economic necessity, if there be intelligent and determined leadership and institutional teamwork:

(a) Closer co-operation between the hospitals of each community to minimize duplication and reduce expenses through co-operative effort.

(b) The provision of adequate accommodations for chronic and convalescent patients.

(c) The closing of uneconomical and unneeded hospitals to eliminate excess beds.

(d) The requirements of a "Certificate of Necessity" for any proposed new construction. This should be issued at the discretion of the Minister of Health of the Province.

(e) A more careful determination of facilities actually needed prior to new construction.

(f) More efficient and elastic planning of new buildings to insure a high average occupancy, and improved methods of construction to minimize operating and maintenance costs.

A well-planned hospital is a practical hospital, requiring a sound minimum investment for construction and a minimum expenditure for overhead and maintenance. The general hospital of the future should be above all so flexible that each bed can accommodate the maximum number of patients a year, and fewer beds be required to carry an average given load. The large wards assigned to different ages, sexes and diagnoses, should be replaced by smaller units, making it possible for a crowded surgical service to use vacant beds on a less crowded medical floor, and so avoid such embarrassments as that of carrying a waiting list on the male service while beds stand empty in the women's wing. Given a properly elastic arrangement we can get along with smaller hospitals which can function up to 90% capacity without overcrowding. The building should be quiet and compact, with all departments properly correlated to insure efficient and convenient care of the patient and the lines of travel of visitors, staff, and supplies must be carefully studied to avoid congestion and confusion. There must be properly grouped elevators, planned food service and adequate storage space. Much has been learned over the years by architects, engineers and consultants in the evolution of the hospital plan—errors to be avoided and improvements to be adopted.

New Hospitals for Old

Many hospitals are finding it impossible to provide complete new plants or even new buildings, but are achieving a great measure of modernity by rejuvenating old buildings, thereby bringing them in alignment with modern requirements for the practice of present day medical technique at a fraction of the cost of new structures.

In the struggles of the past five years to make the drastic cuts in operating cost, which alone have kept the doors open, hospitals have learned that the fundamental factor in economical hospital service is an economical hospital plant.

There are innumerable hospitals housed in old buildings with beds filled to capacity, departments never contemplated in the original plan have been crowded in wherever

space could be found, and much equipment is evident which is more appropriate for a museum than for active service.

Many such hospitals are bravely carrying on with a loyal and devoted staff doing a martyr's job in a hair shirt. The trustees are faced with the urgent necessity for action. The old plant seems hopeless, yet it is equally hopeless to scrap it and finance a new one. What ought to be done? What can be done? How can it be accomplished? Is the old building worth remodelling? If a lot of money is spent on it, will it still be just an old building, or can it be made to serve modern needs in a modern way? If it is structurally sound and lends itself to a practical re-arrangement with convenient connections to a new wing, the answer is usually emphatically "Yes."

The formula for successful results is:

First: Develop a soundly conceived, economical program, the necessity of which can be demonstrated to the community;

Second: Go to the public in a well-organized way supported by constructive publicity. If the money is really needed it will be forthcoming.

Air Conditioning

There are certain fundamental considerations peculiar to air conditioning in hospitals; one of these is that it is not advisable nor desirable to recirculate the air exhausted, whereas in other buildings even as much as 65% of the air is recirculated after being washed and filtered. This indubitably affects the cost of maintenance. Further, it is necessary for the system in hospitals to maintain a pressure above normal to offset positive exhaust systems from the diet kitchens, operating rooms and baths. Also, all doors and windows must be doubly glazed or sashed and weather stripped; all of which increases costs. Nevertheless, in spite of the cost, very careful thought should be given to the desirability of air conditioning the operating department, maternity case room and nursery since, above all departments of the hospital, these units practically demand such treatment of construction. Therefore, even though no other unit be so treated, air conditioning for those above mentioned should be considered.

Lighting and Communication

Workers in the hospital field are becoming more and more light conscious. Poor lighting has been and always will be prejudicial to health and should have no place in the hospital of to-day. The electrical engineer should be definitely instructed where to insert electrical outlets based upon the use of the unit. Before this can be done effectively the furniture must be visualized. In the case of administrative offices, provision must be made for telephones, electric fans, desk lamps, comptometers and other needs not definitely established. In private rooms there should be outlets for telephones, radios, reading lamps, electric fans, floor lamps and outlets for electrical appliances used in treatments. The same rules apply in the wards. The dictograph system now available saves time for the administrator in getting contact with his staff without going through a telephone exchange.

Scientific equipment and furnishings for the new or renovated hospital are always most important ones and the purchase of equipment should only be decided upon after thorough investigation and examination of the various types by the people most concerned in the use of the particular equipment under discussion.

It cannot be stressed too strongly that *equipment should* be scaled and laid out on the plans before purchasing. Patients' rooms are usually laid out by the architects with the major items of equipment located. To do this it is necessary to know the type of furniture which will be provided and the number of pieces. One frequently sees hospitals where the administrator and the architect have completed their plans with a certain scheme in mind only to have the whole set-up disorganized, owing to the fact that groups have gotten together and decided that they will furnish a room or rooms other than as routinely specified. Rather than give any cause for offense to interested parties, permission is given to go ahead with the result that furniture is put in which does not work in with the room size and the general plan of the administrator, so that the result is often not as pleasing as it otherwise would have been. It is much better, even in a very small job, to try to secure donations of money rather than of equipment and then carry out the original idea. Patients' rooms are often overcrowded with unsuitable equipment.

For the guidance of the manufacturer very accurate specifications are necessary.

Private Room Equipment

The newer type beds are much more attractive than formerly, and, as they are now "streamlined" and equipped with every device for the comfort of the patient, they make for greater efficiency in nursing and increased comfort of the patient.

Very important is the bedside table. Study carefully the various types available as recent developments have gone a long way towards solving some of the problems heretofore present in equipment of this nature. One of the newer pieces of equipment incorporates a dictaphone system in the bedside table; this permits two-way conversation between the patient and the nurse without the necessity of the nurse coming to the room. This dictaphone is so sensitive that the patient does not need to turn towards it but merely presses the signal button and, on receiving an answer from the nurse, voices any wish she may have.

Overbed tables are developed to a very high degree of efficiency. They may be raised or lowered and, with an adjustable centre leaf for reading or adjustable mirror for toilet purposes, have proven very popular with the patients. They should have either a brake or a casterless leg on each side to prevent "running away."

All equipment should be thoroughly bumpered in order that there will be no clash of wood on metal or metal on metal. Tops should be covered in blister-proof finishes, which cannot be damaged with alcohol, cigarettes, or any of the dozen other things which usually mark these tables.

Easy chairs should be provided with the necessary footstool equipment in order that the patient, when out of bed, may have a maximum comfort. Slip covers will keep them fresh looking and add brightness.

Colour schemes have been coming rapidly to the fore. Rooms are equipped with venetian blinds, colourful pictures and pleasing drapes on the windows. Chair coverings and rugs give the rooms a more homelike appearance. The therapeutic va'ue is important.

Occupational Therapy and Vocational Training

In the development of a hospital programme, the modern social trend must play its part. The question of how far the hospital responsibility goes in placing a patient back into the community fit to undertake some remunerative occupation must be faced. No modern hospital can be considered complete without having developed some phase of Occupational Therapy and the consideration of developing a vocational programme coupled with a Social Service Department is looming before hospital administrators.

Every hospital administrator sees patients suffering from some chronic disability discharged in a convalescent condition, but who, due to adverse social circumstances, soon return to the hospital to be re-treated. The question of occupational therapy and vocational training can be divided conveniently into four phases:

1. *Diversional:* This phase is usually handled through volunteer committees and, in order to keep volunteers interested in hospital work, the hospital usually has to provide some facilities for them;

2. *Remedial:* The logical development of remedial occupational therapy is as a unit of a hospital in conjunction with the physiotherapy department. Trained workers are essential, proper space allocated, and modern equipment available;

3. *Educational:* This part of the work can usually be done with very little overhead, although in some hospital outpatient departments, room is being provided to-day for educational classes;

4. *Vocational Training:* With a proper social analysis of a case before discharge from hospital, it may be possible to guide a patient during the hospital stay into a vocational department. In such the patient works under medical supervision, building his health back to a point where he is fit to compete with the average individual. Diabetics, cases with chronic heart disease, chronic arthritis, etc., are often kept from repeated hospitalization through this means.

Special Features of Planning and Equipment

Air conditioning for the Surgical, Obstetrical and Nursery Units.

Dehumidification and Humidification of Operating Rooms, bearing in mind that to safeguard against static explosions of anaesthetic gases relative humidity of 55% to 60% is an essential.

Increased use of acoustical treatment generally.

New type equipment for Surgical Units, eliminating white enamel and using chrome plated or new silvertone finish.

Newer developments in sterilizers, using controls which eliminate local vents and reduce to a minimum the escape of steam to the rooms. This applies to low pressure sterilizers.

New controls and alarms on high pressure autoclaves.

Use of ultra-violet rays to curtain off operating area and so reduce infections.

Double filaments in operating room lamps to guard against light failures.

Use of colour throughout the whole hospital plant, making a study of those colours most pleasing and beneficial to the patient, bringing more and more into the hospital picture the atmosphere of home.

Oxygen piped to the patients' rooms for the use of tents, inhalators, etc.

Use of glass blocks for various large surfaces in operating rooms, laboratories, etc. These permit a light transmission of about 85% of that of clear plate glass. They have very definite insulating qualities and where used have appeared to be very satisfactory.

New types of lighting fixtures flush with wall or ceiling surfaces which give a more or less shadowless illumination.

Departmental Consultation Advisable

Hospital administrators should consult continuously with members of the hospital staff, who will be using the facilities to be provided, in order that their thoughts may be incorporated in the layout of the new construction. If the architect be of the type who can co-ordinate all these various ideas (and this is a necessary attribute), he should be able to effect a whole which will adequately provide for all the requirements of each department in the completed hospital.

If we broadly appraise the trends in hospital design during the past two decades we find:—

More consistent progress in the scientific than in the business side.

Tendency in the space budget to overemphasize the professional at the expense of administrative and non-professional necessities.

Tendency to overlook many major and minor improvements which would contribute to the comfort and peace of mind of the patient.

Too frequent disregard of the essential details of soundly conceived plans and specifications which minimize overhead, maintenance, and operating costs.

Reluctance to revise ideas, discard impractical experiments, and above all to simplify the building and mechanical plant.

Our Task

If we are to meet future problems effectively, there must be reconsideration of many hospital policies and practices and a redefinition of hospital building standards. In the struggle of the past years to cut the deficit we have learned that the greatest waste in hospital operation is avoidable waste, excess beds, inelastic, unbalanced design, and exorbitant overhead due to over-large, over-elaborate, over-complicated hospital plants.

To achieve the ideals of the hospital trustees and administrators in providing an adequate service to every patient brought to the hospital without imposing an additional burden upon those who are able to pay their way, we must plan our hospitals to permit the greatest economy of operation and thus do our part in reducing the cost of hospitalization.

Your Committee would ask that reference be made to the two previous reports of the Committee on Construction and Equipment published by Canadian Hospital Council Bulletins No. 3 and No. 10 in the years of 1933 and 1935 respectively; and further would stress the value of the information contained in these reports since it it not the wish of this committee to duplicate the work of previous committees.

RESOLUTIONS

Canadian Hospital Council—1937

Local Committee on Arrangements

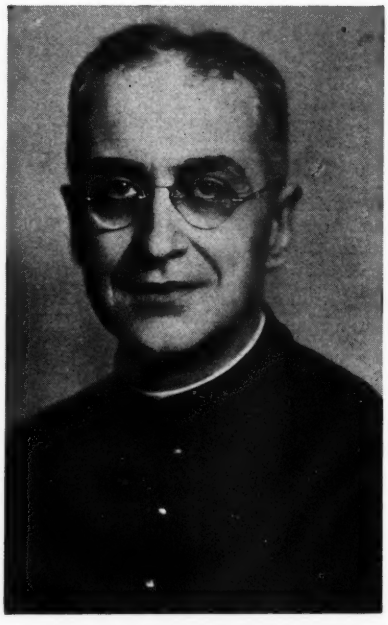
RESOLVED that this Council extend its sincerest thanks to the Local Committee on Arrangements upon the warmth of the hospitality and the cordiality of the welcome extended to the delegates. (Carried).

Ottawa General Hospital

RESOLVED that this Council extend its sincerest thanks to the Ottawa General Hospital for the warmth of its hospitality and the cordiality of the welcome extended to the delegates. (Carried).

Chateau Laurier

RESOLVED that this Council extend its sincerest thanks to the Chateau Laurier for the excellent facilities provided, and for the obvious efforts of all members of the staff to make the arrangements for the meeting as perfect as possible. (Carried).



Rev. Father Georges Verreault, President, Canadian Hospital Council.

International Hospital Association

WHEREAS the Canadian Hospital Council learns with extreme delight that during the year 1939 the International Hospital Association will meet for the first time in Canada,

THEREFORE BE IT RESOLVED that this Council, realizing as it does, the outstanding importance of such a notable event in the hospital life of this nation, and the beneficial effects that will flow to all the people from the visit, extend to the International Hospital Association and its delegates a deep and sincere welcome to Canada, and pledge its co-operation in every way possible.

AND FURTHERMORE, WHEREAS the American Hospital Association will again honor Canada with its presence during the year 1939, and whereas it is recalled that a former meeting of that Association held in Canada was productive of salutary and lasting benefits;

THEREFORE, BE IT FURTHER RESOLVED, that the Council cordially welcomes the Association to Canada and gives to it its assurance of assistance and co-operation. (Carried).

Customs Tariff and Sales Tax

WHEREAS the aids which have been given to hospitals in Canada by concessions in the way of customs tariff and sales tax exemptions have been of incalculable benefit to hospitals and to the sick and needy.

BE IT THEREFORE RESOLVED that this Council express its gratitude and thanks for the sympathetic treatment and kindly consideration shown in these matters by the Federal Government. (Carried).

Tariff on X-rays

WHEREAS the preference given to British manufacturers of X-ray equipment by a duty of ten per cent has worked a hardship on Canadian hospitals, particularly in the matter of timely serviceing and the delay in securing equipment, without having the effect of assisting British trade;

THEREFORE BE IT RESOLVED that the Dominion Government be requested to arrange for the removal of the ten per cent duty on X-ray equipment. (Carried).

Farmers' Creditors' Arrangement Act

BE IT RESOLVED that hospitals in Canada should be placed upon the preferred list of creditors under the Farmers' Creditors' Arrangement Act. (Carried).

Home Improvement Act

WHEREAS many hospitals throughout Canada are desirous of effecting improvements, additions and alterations in their plant and equipment, but are prevented from doing so or are handicapped in their efforts by the difficulty of securing money loans at low rates of interest;

AND WHEREAS if hospitals were able to carry out these extensions much building material would be purchased and employment increased; and furthermore that such hospital improvements would improve the efficiency of hospitals and their service to the public;

THEREFORE BE IT RESOLVED that this Council request that the Home Improvement Loan Act be amended so as to extend to hospitals in Canada. (Carried).

Hospital Contracts

BE IT RESOLVED that hospital contracts should not be entered into by hospitals at less than the per diem cost. (Carried).

Health Insurance

WHEREAS there would seem to be a definite trend in Canada towards governmental control and socialization of health services, or to what is known as "health insurance";

AND WHEREAS this matter is of vital and paramount importance to the whole hospital structure of Canada;

THEREFORE BE IT RESOLVED. (a) that all

(Continued on page 56)

Dr. Agnew to Preside at International Meeting in Toronto in 1939

AT the convention of the American Hospital Association, held in Atlantic City in September. Dr. Harvey Agnew was chosen President-elect, and will assume office in September of next year. Dr. Agnew will therefore be host at the conjoint meeting of the International Hospital Association, the American Hospital Association and the Canadian Hospital Council, to take place in Toronto in 1939.

It is particularly fitting that Dr. Agnew, who is well known in hospital circles in Europe, as well as throughout the United States and Canada, should be chosen to preside during the year which will bring together, in Toronto, delegates from the leading countries of the world.

This is but the second time a Canadian has been so honoured by the A. H. A., Dr. George F. Stephens of Winnipeg having served as President in 1932.

We congratulate Dr. Agnew on his high, but well merited honour.

American Hospital Association Holds Record Meeting In Atlantic City

THE September meeting of the American Hospital Association was one of the most successful in its history, approximately 5,000 people being in attendance. Attendance at one of these mammoth conventions with its five-ring circus of sectional meetings, its marvellous display of commercial and educational exhibits and its unexcelled opportunity to hear and confer with the hospital and health leaders of this continent is an experience long to be remembered. While one regrets not being quintuplets in order to take in all of the meetings going on simultaneously, there is the satisfaction of knowing that every minute of the week can be utilized to follow up some subject of special interest.

A Reminder!

The Fourteenth Annual Convention
of the
Ontario Hospital Association
Will be Held at the Royal York Hotel
Toronto, Oct. 20-22

The Program Appears on Pages 76-79

The program is getting heavier each year. Not only is there an unusually good program arranged for the last day, which used to be poorly attended, but the allied associations meeting with the A.H.A. start their meetings during the previous week. The sessions of the American College of Hospital Administrators, which now come in over the week-end between the meetings of the Protestant Hospital Association and the American Hospital Association, bring together the outstanding figures in hospital administration for a very interesting program.

The program itself is far too vast to permit any adequate review in these columns; the full transcript will appear in due course in the bulky volume of the Transactions of the Association. From the viewpoint of the future welfare of the Association itself, the outstanding achievement was the passage of the new Constitution, which places the Association on a basis better adapted for future development, and which is more in keeping with the extent of its present activities. This is of interest to Canadians in as much as the members in each province will have the privilege of naming one member, or possibly more, to the new House of Delegates, which is being set up for the legislative work of the Association. An unusually large number of Canadians were in attendance. Congratulations upon the success of the meeting are in order to Dr. Claude W. Munger, President, and Dr. Bert. W. Caldwell, Secretary.

DO PATIENTS FEEL LIKE THIS ABOUT *Your Hospital?*

YOUR patients' recovery is often speeded by little attentions that contribute to their comfort. Little home-like gestures . . . attractive serving trays . . . even the soap you provide. Such details help your patients more than you may realize.

Why is soap an important detail?

The soap you provide is important because it is noticed by every patient. When you provide Palmolive, *the world's favourite toilet soap,* you please the greatest number of your patients, for more people use Palmolive at home than any other toilet soap. And because Palmolive is made with olive oil, it will be *doubly* appreciated—for its creamy, fast-cleansing lather soothes the tenderest skin.

Palmolive lathers richly in hard or soft, hot or cold, water. It is the purest soap you can buy . . . is hard-milled . . . lasts extra long. And Palmolive is a *natural* olive oil colour.

Send today for free samples and prices. Choose the size you like best. A trial order will prove that Palmolive is good for your hospital and will save you money. We offer this guarantee. Unless you are perfectly satisfied with your trial order, your money will be refunded. Let us take the risk.

Soap is just about the only familiar trademarked item that you provide for your patients' use. Why not give *your* patients Palmolive, the one soap most people prefer? It's more economical.

FOR YOUR WASH ROOMS

the Palmolive "Measured Soap" System brings you a special dry free-flowing bead form of the world-famous Palmolive Soap . . . in a sturdy dispenser that accurately "measures out" just enough soap for one wash at a time.

Gives more than 100 washes for 1c

PALMOLIVE SOAP

A Product of Colgate-Palmolive-Peet Co. Ltd.

Montreal TORONTO Winnipeg

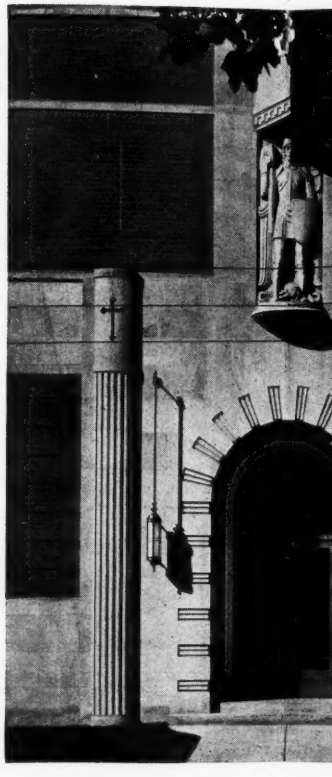
St. Michael's Hospital, T
Appointed $50

By SISTERS OF ST

THE thirty-five bed hospital opened by the Sisters of St. Joseph of Toronto in 1892 was the nucleus of the splendid building that has just been completed. Approximately every ten years, during the past forty, the Sisters have built extensively, and with the opening of this new central part, which replaces the site on Bond Street where the hospital saw its beginnings, a completion of the hospital is effected.

This half million dollar, eight story unit provides administrative offices, staff rooms, clinical and assembly rooms for the doctors, and increases the number of patients' rooms — the capacity now being 690 beds. It also accommodates the living quarters of the Sisters in charge of the hospital, and a new Chapel that fulfills a dream of over forty years.

The building is of pressed brick with limestone trim; it is modern in design and was planned by W. L. Somerville, Architect, Toronto.



Imposing new entrance at St.

The New Unit in Detail

Vestibule and Entrance Hall—Large bronze doors lead to a vestibule which is separated from the Entrance Hall by a double flight of steps and a wrought iron screen. The magnificent entrance, with terrazzo floor in pattern, has a black and gold marble base and dado; pilasters and upper dado of Batticino marble, and a ceiling of ornamental plaster. The concealed radiators have removable panels.

The furniture in the Entrance Hall was designed to harmonize with, in fact to be a part of the architectural design of the interior. Simple, yet dignified in character. A central table in bleached maple and inlaid with ebonized birch, geometric in design, conforms to the geometric form of the Terrazo floor.

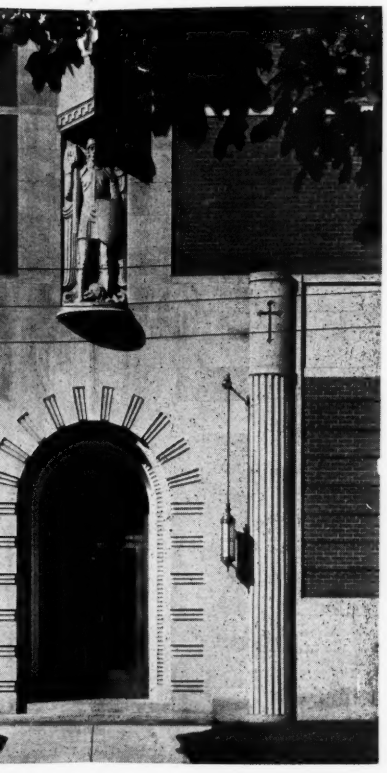
Three benches in green leather on bases of maple and

Illustrations: Left, top to bottom—
Entrance Hall.
Sister Superior's Office and Board Room.
Visitors' Sitting Room.
Medical Staff Library.

Photos courtesy of T. Eaton Co. Limited.

ital, Toronto, Opens Well ed $500,000 Unit

ISTERS OF ST. JOSEPH



entrance at St. Michael's Hospital.

erville,

s lead
e Hall
. The
has a
upper
l plas-
s.
ed to
ectural
racter.
onized
metric

le and

mited.

ebonized birch, and a writing table and small chairs also in green leather and framed of bleached maple, add to the attractiveness and utility of the entrance.

The administrative offices are separated from this hall by wrought iron screens and plate glass, acid treated to make it obscure.

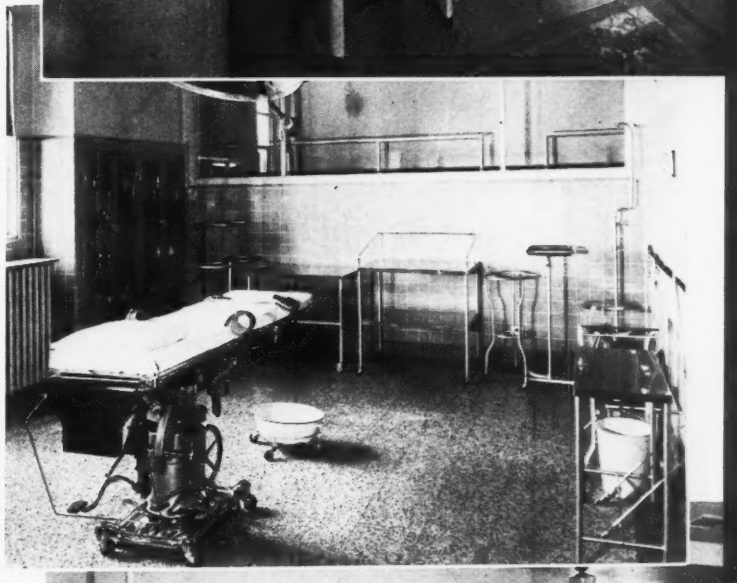
Ground Floor

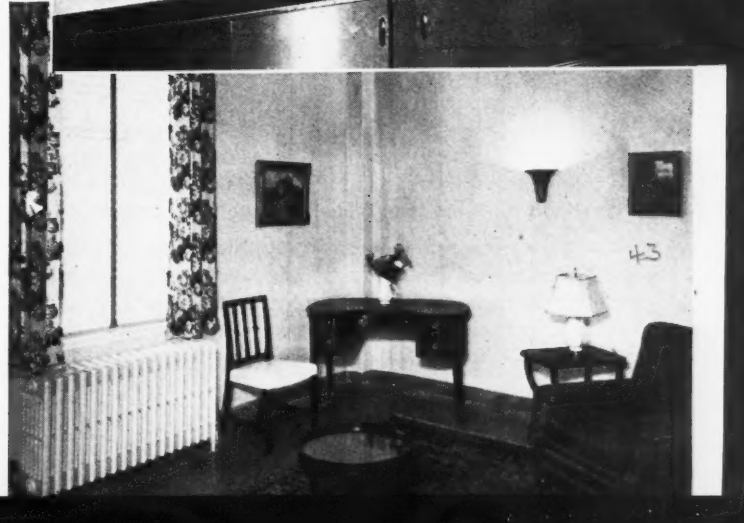
The large central kitchen and all adjoining supply rooms, and two large attractively furnished dining rooms with servery between for the graduate and under-graduate nurses, are located on this floor. There are several large windows with areas, and the equipment in the servery includes electric dishwashing machines and Monel metal sinks.

Central Kitchen — The chief feature of this floor is the Central Kitchen from which food is prepared and served for more than 5,000 meals each day. It is well lighted and ventilated and finished in gleaming white tile. Steam-serving counters and metal plate warmers with vegetable containers ensure the service of piping-hot meals.

The large food containers are conveyed to the Diet Kitchens speedily and with precision. There are some ranges electrically equipped, some steam ovens, all of which contribute toward the very important factor of having the attractive meals served at desirable temperatures.

The milk and cream is kept in the immense electric refrigerators, and all other supplies requiring regulated temperature are in separate rooms, convenient to the kitchen staff. The bakery is an efficient establishment at the north-east corner of the kitchen. All modern labour and time-saving equipment is used, and the result is that the central kitchen presents a scene of absolute order and spotlessness.





Illustrations: Right, top to bottom—
Private Patient's Room.
Operating Room.
Main Kitchen.
Sitting Room en suite with Private Room.

Main Floor

At the top of a short flight of steps from the Entrance hall, is the enquiry office and opposite the main office and the various accounting offices, as well as the offices of the Secretary and Assistant Superintendent. On the west side at the north end of the corridor is a Tuck Shop, a very convenient spot for the patients and their visitors which combines with its sundries a lending library. Near the visitors' parlour are wash rooms, and at the end of a short corridor is the large staff room with light on three sides, and adjacent wash rooms and coat rooms. The electric register is just outside the staff room door, where the doctor switches on a light when he arrives. This same keyboard, which has a duplicate in the telephone operators' room, may indicate that there is a message for the doctor. The Board Room and Sister Superior's office is illustrated.

Figure symbolical of St. Michael in Main Entrance.

Sister Superior's Office: Stately and spacious—the walls in two tones of grey contrasting with the walnut panelling and inlaid block walnut floor. The furniture in select walnut grain, leather upholstered, was designed to harmonize with the architecture of the room and to carry out the purpose for which the room was planned, that of combination office and board room. Venetian blinds in the modern manner allow privacy while providing plenty of air and light. The blinds and the modern yet unsevere lines of the desk introduce a pleasing lack of the usual office severity. The trimming of ebonized strips with the walnut panelling in this office is very effective.

Second Floor

On the north side is the Medical Library, the Chaplain's dining room, and a large dining room for guests, with a severy between. Next to the interns' bedrooms is the Newman Club Library for the patients, and a cloak room. The whole of the south side is occupied by the spacious Assembly Room and Central Surgical Supply Room.

The Assembly Room: A very simple scheme of colour has been adopted to serve as a suitable background for the various occasions to which this room will be used for different purposes, as a meeting place or lounge room for the Doctor's Committee meetings and as a lecture room.

The furniture design consists of four simple groupings of a Settee covered in red leather, four chairs in beige fabric on and about a plain green broadloom. End tables and larger tables are in walnut.

The curtains are made of two toned crash woven in a simple diagonal pattern and the walls are painted a warm grey similar to the tones of the crash.

On the end tables at either side of the four red settees are lamps in walnut with shades of natural crash.

The Central Supply Room has been equipped with care, and it facilitates greatly the supplying of the various floors. It expedites the nursing care of the patient and is valuable in teaching the student nurse. Loss and misplacement of supplies are reduced to the minimum, and a marked economy of space on the floors is effected. All elevator service is convenient to the Supply Room, and every tray sent from here is returned after the treatment for cleansing and replenishment. A definite economy of time and labour is accomplished by having one staff handle the supplying of surgical goods and treatment trays. The sinks are of Monel metal and the tables and cupboards have been specially designed for the segregated placement of instruments, needles, tubing, etc. The Central Surgical Supply Room has an atmosphere of complete service, efficiently directed. The equipment includes a thermostatically controlled cupboard for solutions, autoclaves and stills.

The Doctors' Library: A haven where the busy doctors may slip in for a moment's quiet reading. It is furnished in Old English Oak with a block oak floor, oak panelling with inlaid strips of walnut and built in bookcases behind which are the stacks. At the other end of the room are the magazine racks and conveniently arranged sections for the files. The long oak table and high backed library chairs, upholstered in dark green leather, provide that desired professional atmosphere. The natural crash drapes and indirect lighting complete a scheme in which nothing is allowed to interrupt a feeling of relaxation and quiet.

Third Floor

The Third Floor is occupied by the Chapel, the Chaplain's apartments, a parlour and the Sisters' dining room. The Chapel is described in detail elsewhere in this issue.

Fourth Floor

The Fourth Floor is taken up for the most part by patients' rooms, as is the sixth. All corridors are of terrazzo and inlaid linoleum, and with the accoustical plaster are sound-proofed, as are the doors and windows. Vacuum outlets are provided in a number of the patients' rooms, and oxygen has been piped to them from the central supply room. Each floor has a blanket warmer and graduate and under-graduate nurses' stations.

Fifth Floor

The Operating Rooms: The walls of the new Operating Rooms are of pearl grey tile. The floors are beautifully finished terrazzo with brass strips in block effect. All brass strips are welded together and wired to a ground to prevent static sparks. The windows are double glazed. All equipment, including the recessed Monel metal cabinets for supplies, are finished in a quiet silver tone. With the thought too for providing every aid to the surgeons that scientific endeavour has produced, these rooms have the latest equipment. Each Balfour table, finished in silver tone, is provided with a Scialytic light, and all the other lighting fixtures are flush with the ceiling. There are X-ray view-boxes and vacuum piping for use during operations. In each room there is a niche for a bottle and a vacuum line, so connected that the amount of vacuum on the bottle may be varied. This vacuum is produced by an electric-driven machine in the basement and a storage tank is provided on the line close to the Operating Room Section to keep the vacuum constant. The Sterilizing Rooms between all the Operating Rooms are fully equipped with scrub sinks and all their appurtenances, including shelves of Monel metal. Here, too, are large metal cabinets for sterile supplies, water-tanks thermostatically-controlled, solution cabinets, and instrument warmers. The glassed-in observation galleries have a separate entrance from the hall. Electric clocks are seen in all Operating Rooms, Sterilizing Rooms and halls.

Included in the Surgeons' suite is the pleasingly furnished Lounge Room with adjacent Locker Rooms, shower and wash-up room.

A complete ventilating system has been installed for the operating rooms both old and new. There is one supply fan with filter, heating coils and humidifier all automatically controlled and this supplies sufficient fresh air to completely change the air in each operating room every ten minutes. This air is drawn from outside at the roof level and passed through filters to clean it and then through heating coils and the humidifier which are both automatically controlled so that the air may be delivered to the rooms at any desired temperature and humidity.

The air enters the rooms through directional flow grilles which are designed to distribute it over the whole room which is impossible with the standard grille. The inlets are placed about 8 feet above the floor. The air is exhausted from each room through a grille located near the floor and is connected by ductwork to an exhaust fan which drives it out of the building.

Sixth Floor

Visitors' Sitting Room, sixth floor, is a far cry from the old fashioned waiting room. It is cheerful and bright with its natural finished rattan furniture, the comfortable spring cushions being slip covered in a rich brown chintz, patterned with cream and yellow narcissus. The covers are removable for cleaning. The walls are light and lend a pleasing tone of cheerfulness. The inlaid linoleum floor in terra cotta shade adds a final home-like touch.

The Private Rooms: Upon entering the new private rooms on the fourth and sixth floors, one's first and most arresting impression is the lightness and bright airiness of all pieces of equipment forming the furnishings of these spacious rooms. A complete detachment from any atmosphere of hospital or the institutional has been achieved and they become at once the cheery well appointed bedrooms of the up-to-date furnished home. Upon close inspection, it is found that this bright note does not stop at the new and pleasing colour of the sturdy wood furniture, but is carried through to an effective climax in the general design, and construction, to a point where it offers facilities for the comfort of patients and at the same time a further step in advancing service to the occupant, reducing maintenance to a minimum.

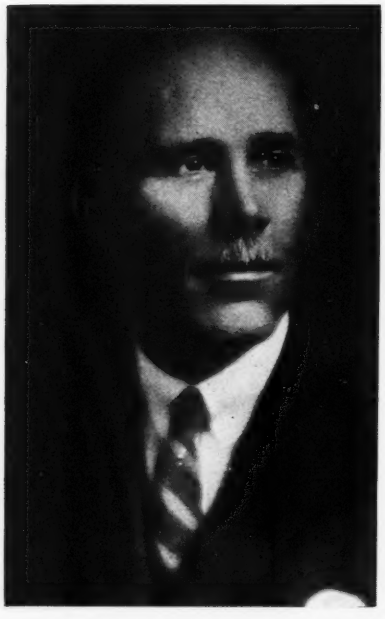
Instead of the conventional walnut or walnut-finished woods with their highly polished and easily marred surfaces, natural red oak of a healthy biscuit shade has been used, and it has been found that this oak when finished with a hard, clear satin lacquer well rubbed surface is stain and practically fool proof.

The designs are distinctly modern, but of a very practical type. The dressers, bedside tables and footstools have no legs and are slab flush panel sided, rounded at extremities, built to the floor and recessed at base for toe room, with heavy black linoleum covering the entire recessed base as a kick buffer, at the same time enhancing the general decorative scheme by its contrasting note. All drawers are flushed back with no drawer divisions showing and even the drawer pulls have been recessed with only a half circle of heavy brush chrome metal protruding its own thickness. The tops of the dresser, bedside table and overbed table are covered with a new blisterproof formica having a linen grain finish which does not mark or burn and blends in very well with the wood finish. Around the edge of the bedside table is a rubber beading protecting the top and sides from bumps and the walls from damage. While the dresser and bedside table appear to be built to the floor, hidden rubber tired casters are installed permitting these pieces to be easily and quietly moved for the occupant's convenience. A separate mirror of generous proportions to match the dresser is attached to the wall above it. The bedside table is noteworthy for its convenient features for the patient; higher than usual the service opening faces the patient with a reversible drawer so that items desired can be placed in without moving the table or disturbing the patient; a sliding shelf under the top extends out over the mattress forming an arm or book rest at arm level, besides other numerous uses.

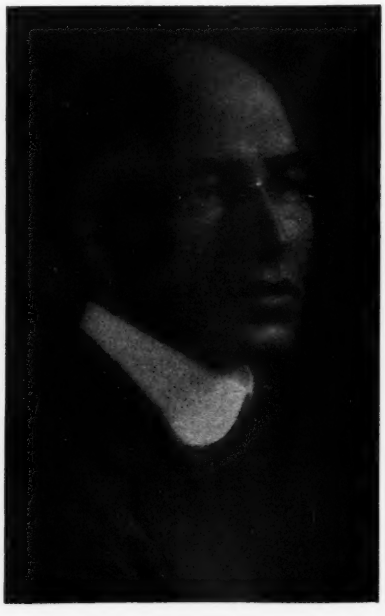
The overbed tables are quite unique being of a pedestal type which can be raised or lowered by the patient. The top is for the service of meals, or inclined in the centre section after meals, for a reading stand, or reversed to reveal a convenient mirror placed that it can be used in different angles to suit the patient whether sitting or lying, it must be a most companionable piece of equipment for the patient. The beds have a distinctive touch, being apparently of wood as their plush panels with black rubber bumpered top and sides would denote, but actually all suspension is of steel. These beds have an adjustable brush chrome bed lamp which fits in a hidden socket at either side of head of bed or at the foot. These beds have a very unhospitalized look about them and are extremely clean cut and attractive in effect.

The easy chairs are especially designed for comfort and correct sitting posture when relaxed. The curtains are of

new floral cretonne designed in the modern manner; of pastel shades, they are nevertheless absolutely fast to sun and washing and allow the light through without destroying in any way their varied colors. New floral pictures adorn the walls to complete a room that has all the comforts and conveniences that modern progress has arranged.



DR. GEORGE E. WILSON,
Chief of Surgery.



DR. JULIAN LOUDEN,
Chief of Medical Staff.

DR. D'ARCY FRAWLEY,
Chief of Obstetrics and Gynaecology.

In Appreciation

"IN the name of the Sisters of St. Joseph I should like to pay a tribute of thanks for the whole-hearted co-operation of the people of this Province, of this great city of Toronto, of our noble University, our medical and nursing profession, and the great general public whom this hospital strives to serve and upon whose favour and patronage the institution depends. To all of these, I tender our sincere thanks for the spirit of cordial co-operation which they have uniformly shown.

It is a pleasant and encouraging sight to see all parties co-operating with a pure esprit de corps so voluntarily and gladly for a great object, and I tender my congratulations and fervent wish that this same tranquility of order from which issues peace and good will may happily continue.

May I further thank the medical men, the nursing profession and the Board of Directors for their self-sacrificing spirit of duty and generous interest in every phase of St. Michael's welfare. The men who form the Board of Directors and the members of the medical staff of this institution, are men not only of high scientific culture and value but they constantly prove themselves to be men of moral worth, of high principle, probity, of honour, of Christian benevolence and of heroic unselfishness. The nurses who play such an important part in the functioning of the modern hospital show by their conduct and work that they receive not only training along technical lines but also in the formation of character.

Finally, I do not forget the great general public and I now refer to the rich and poor, the educated and the unlettered, Protestant, Catholic and Jew, those of every race and denomination which this institution is pledged to serve and upon whose good will and support it depends. We thank the city of Toronto for its helpful interest. In the same spirit, we hail the Province of Ontario, for our patients come from every corner of it and we thank the great body of men and women whom we wish to help in the hour of need and whose sympathy and kindness make of this a labour of love. Of the poor we are thinking particularly, and I want to say publicly that it is the wish of the Church that St. Michael's Hospital open wide its arms to the poor and under privileged in the spirit of Christ. Each year I receive a record of its charity and I am profoundly thankful for the opportunities afforded the Sisters to exercise the charity of Christ to those upon whom misfortune has fallen. Mercy is nobility's true badge."

(Excerpt from the address given by Most Rev. J. C. McGuigan at the Civic Opening of St. Michael's Hospital.)

* * *

"In St. Michael's Hospital we realize that the science of healing owes its spirit and inspiration to the call of religion. The modern hospital cannot but accomplish good if it be animated with the spirit of God. We look for inspiration and help to Him who 'went about doing good and healing all manner of infirmaties'. I feel sure that this will always be your spirit.

"The University of Toronto hails you and wishes you well from our heart."

(Excerpt from Canon Cody's Address.)

Forty-five Years of Progress at St. Michael's

IN a span of four and a half decades to one of the largest hospitals in the Dominion, is the proud record of St. Michael's Hospital, Toronto.

The Sisters of St. Joseph are to be congratulated on their fine new Pavilion just completed, which adds so much to the hospital facilities of the City of Toronto.

Simpson's Hospital Contract Department was again selected for the important task of designing and supplying the Special Private and Semi-Private Room furnishings and equipment, together with several major items in their new kitchens.

Simpson's

Toronto — Montreal

Opening Ceremonies at St. Michael's Hospital

Left to right:—Sir William Mulock; Senator F. P. O'Connor; Sister Margaret, Superior General; His Honor the Lieut.-Governor, Dr. Herbert A. Bruce; Sister Norine, Superior; Mr. Duncan McDougall, Chairman, Board of Governors; His Excellency, J. C. McGuigan; His Worship Mayor Robbins; Mrs. Bruce.

Tribute From Lieutenant-Governor

"I HAD the privilege of receiving some of my early training in St. Michael's Hospital and I wish to pay a tribute of thanks to those in charge of this institution for the assistance I received here in my surgical work. I am sure that in those early days I received the confidence which is so necessary in surgery. It was imparted to me through the kindliness of those connected with St. Michael's.

The roll call of those who gave to the Hospital their services and an impetus in the way of advancement include such justly celebrated names as Dr. Robert Dwyer, the skilled physician, Col. Walter McKeown, who gave his services to his country in the Great War, Doctors Silverthorn, Guinane, Wallace Oldright, Norman Allan, J. F. Ross and P. J. Brown. To-day St. Michael's Hospital may well be classed as one of the best equipped hospitals on the continent and an institution of which the citizens of Toronto may be justly proud.

St. Michael's Hospital has been singularly favoured in the class of physicians who serve it. Dr. Julian Loudon, chief physician, Dr. George Wilson, head surgeon, and Dr. D'Arcy Frawley, obstetrist and gynaecologist, are names truly representative of the staff which this hospital employs. I should like to pay special tribute to those who in many cases are overlooked. I have in mind the Sisters and Nurses of St. Michael's Hospital. While I can never hope to tell the story of all they have done and will do, I wish to pay special honour to their profession which as Sister and Nurse seems to me the highest to which womanhood may aspire. The gracious name of Sister and Nurse express their manner of calling and the kindly deeds which they have done will be recorded in letters of gold."

Excerpt from address by his Honor, the Lieut.-Governor of Ontario, Dr. Herbert A. Bruce, at the official opening.

The New Chapel at St. Michael's Hospital

THE ground plan of the new Chapel at St. Michael's Hospital is of the simplest: a single nave, terminating at its eastern end in a chancel or sanctuary flanked by two sacristies. Transverse arches divide the nave into four narrow bays. Broadly pointed, these main arches contrast with the lancet form of the triumphal arch separating nave and sanctuary end of the arches which frame the two side altars. A modern touch is achieved in the Gothic inspiration of the chapel by starting the curve of the arches almost from the floor-level instead of having them rise from supporting piers or wall brackets as was the mediaeval custom. Above the entrance a spacious gallery looks out upon the Chapel, separated from it by a wrought iron grille. The walls and arches are finished in rough plaster of a neutral beige tone, a distinctly earthy hue, whereas the ceiling carries a suggestion of the

"WORK ONCE OCCUPIED FIFTY PAGES...NOW OCCUPIES ONLY ONE WITH "NATIONAL"

Says SUPERINTENDENT OF ST. MICHAEL'S HOSPITAL

St. Michael's Hospital
Toronto Canada

September 27, 1937

National Cash Register Company
of Canada Limited,
222 Lansdowne Ave.,
Toronto, Ontario.

Dear Sirs:-

We have much pleasure in relating our experience with the National Cash Register Accounting Machine.

This machine has been in use here for several years and has given entire satisfaction. Its chief appeal lies in the marvellous rapidity and the simplicity of operation. From an economical standpoint it has proved a genuine success as the fact that it stores the totals for the various departments, enables the operator to reduce work which formerly covered fifty pages, to part of one page.

Trusting that we have answered your inquiry to your satisfaction, we are,

Yours very truly,

ST. MICHAEL'S HOSPITAL,

Sister M. Norma
Superintendent.

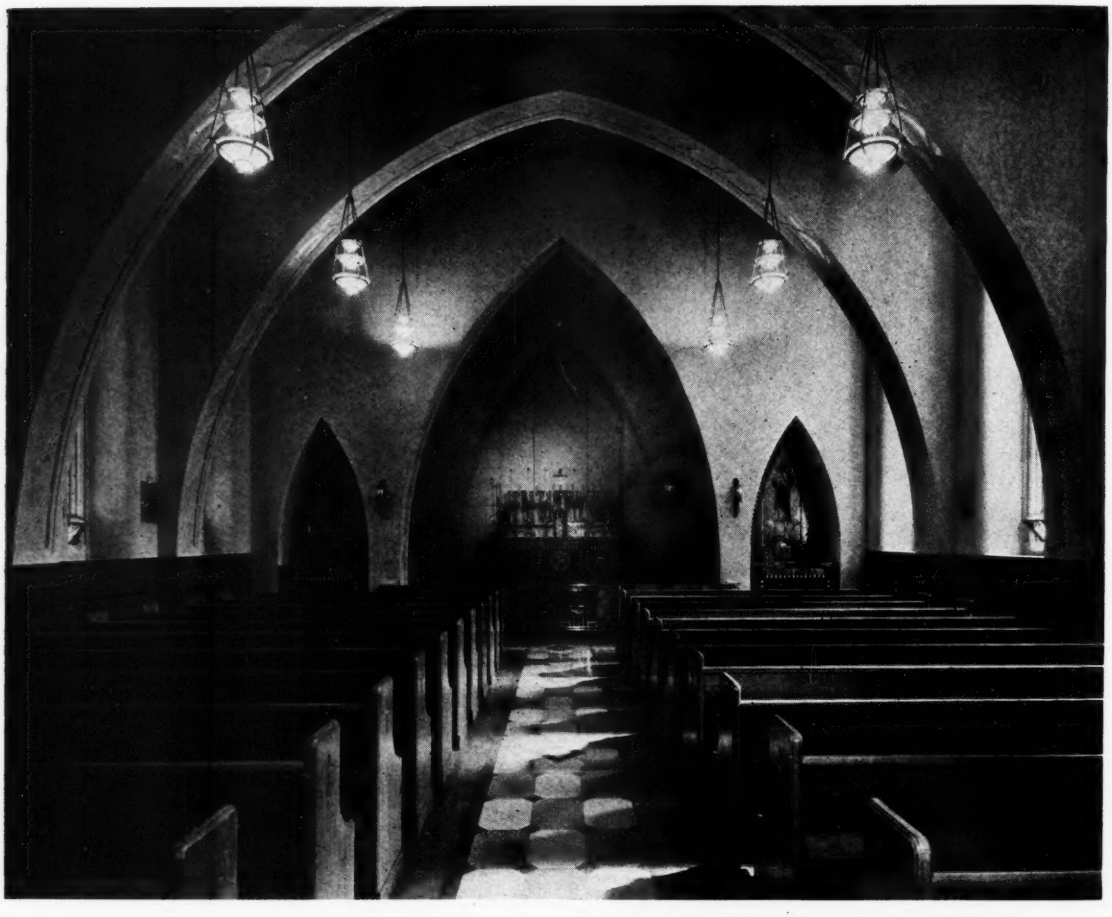
In Institutions and Businesses . . . in every Activity that calls for accuracy in transactions . . . there is a place for National Cash Register Systems. For a National eliminates needless hours of routine . . . it simplifies work and whittles down effort to vanishing point . . . it provides all needed information at a glance . . . and it gives complete, unerring mechanical control of all moneys, transactions and records.

Phone our representative nearest you. He is willing and qualified to suggest a National System to meet your requirements.

THE National Cash Register Company OF CANADA LIMITED

Head Office and Factory: TORONTO **Branches in all Principal Cities**

CASH REGISTERS • TYPEWRITING-BOOKKEEPING MACHINES • ANALYSIS MACHINES • BANK-BOOKKEEPING MACHINES • CHECK-WRITING AND SIGNING MACHINES • POSTAGE METER MACHINES • CORRECT POSTURE CHAIRS



Simple Dignity is the Keynote of the New Chapel at St. Michael's Hospital, Toronto.

heavens with its beautiful caerulian blue whose effect varies according as it is seen in the daylight which pours through the four long square-headed windows in either nave wall or under the artificial light thrown up from electric fixtures of pleasing modern design.

A stained-glass panel of the Sacred Heart is in the first window on the south side, and facing it in the corresponding window of the north wall is a similar panel depicting the Blessed Virgin. The centre window represents St. Joseph, Patron of the Community, and in the fourth window St. Elizabeth of Hungary is portrayed. The other windows are unadorned, except for the leaded design which weaves its way throughout, dividing each window into hundreds of tiny glazed spaces; the general effect is not unlike that of early Cistercian grisaille work which produced in windows a chaste beauty quite different from the warm glow of stained glass.

Relief is given to the solid tones which prevail in the nave by the richly coloured Stations of the Cross. Based on a Daprate creation, they have been tinted by artists from the Anthony Studios of New York. To obtain the very best effects in the light available, the artists came to Toronto to execute their work after the Stations were mounted in place. Seven bright patches of colour flash along either wall, like miniatures from a thirteenth century manuscript. The blues and greens, and especially the red of Our Saviour's costume, stand out against the gold background as sharply as in the work of the mediaeval illuminators. The scenes are, for the most part, simply portrayed: no crowding of figures, no attempt to fill in a background of Jerusalem or Calvary's mound; the whole attention is centred upon Christ and His Cross. The plain rectangular shape of each station is in harmony with this simplicity of line, while the painted border of parallel bands stresses once more the other chief characteristic of the work, richness of colour.

In spite of the tendency of the arches to carry the eye upwards, the line of the low-placed Stations and the oak panelling which runs the full length of the side walls produce a horizontal effect which draws the attention unerringly to the focal point of the Chapel, namely the altar. The main altar is a work of exceptional art and beauty. Behind a communion railing of Bocatello Sienna marble, it stands on a three-step platform of Verde Antico marble. The altar itself, complete with retable and reredos is also of Bocatello Sienna marble whose rich natural beauty is brought out the more by inlays of Verde Antico and a chevron border of alternating white and black marbles. The frontal is further adorned with mosaic inlays; its central panel discloses a medalliion depicting the Lamb of the Apocalypse bearing the cross and the flag of victory recumbent upon the Book of Seven Seals, in the lateral panels are the Greek uncials, Alpha and Omega. In altar design there is a faithful compliance with liturgical re-

quirements. The free-standing tabernacle, the detached gradine, the candlesticks and crucifix arranged in a straight line in the background are all in strict conformity with the rules laid down by the Sacred Congregation of Rites.

The spirit of the new liturgical movement has been carefully guarded. The side altars dedicated to Our Lady and St. Joseph, while in strict harmony with the plan and colours of the main altar, utilize for the portrayal of the two holy patrons gold mosaics set in the wall behind each altar. At the rear of the Chapel is a Shrine of the Sacred Heart.

Were one to mention at random the other bits of beauty, the shrine of Our Lady of Perpetual Help, the hand-wrought brass brackets of the sanctuary lamps, the artistic heavy panelled doors of the entrance and of the built-in confessional ought not to be omitted.

Beauty and simplicity of line, richness and harmony of colour, these are clearly the predominant notes struck everywhere throughout this beautiful new chapel, making it a worthy addition to the architecture of the City, and a pioneer in Toronto of modern Catholic art.

In referring to the Chapel in his sermon at the religious opening on September 8th, Msgr. Cline made the following appropriate observation:

"While the patients of 690 beds will rely on surgical art or medical skill for a return of lost health, a greater number of spent and tired toilers, forsaken and forgotten in the market place of life, will seek strength and refreshment and a kindly remembrance in this divine pharmacy of Christ. If physician and surgeon dominate the bodily services of this great hospital, should not the Master Physician have a clinical ward in the central building? If the Good Samaritan outlined the first Christian hospital and prescribed the ethics that ought to guide it, should He not hold presiding place in this palace of healing?"

Hospital Standardization Conference to be Held in Chicago, Oct. 25-29

The Twentieth Annual Hospital Standardization Conference will be held at the Stevens Hotel, Chicago, October 25-29. An extensive program has been arranged with Eugene H. Pool, M.D., New York, President of the American College of Surgeons, presiding.

In addition to the meetings which will take place in the Stevens Hotel, the Association of Record Librarians of North America will hold conjoint meetings at the Stevens Hotel and also at the Grant Hotel.

A number of demonstrations will be conducted in the principal hospitals in the city, under the direction of such well known hospital administrators as Asa S. Bacon, Paul H. Fesler and many others.

Among the Canadians who will take part in the Conference are Harvey Agnew, M.D., Toronto, newly chosen President-elect of the American Hospital Association, who will address the Meeting on "Trends in Medical Education as Affecting Hospitals Offering Internships and Residences"; George E. Wilson, M.D., Toronto, who will preside at the session devoted to Medical Staff Conferences, and Harold L. Scammell, M.D., Halifax, who will take part in the discussions dealing with hospital personnel management.

RESOLUTIONS

(Continued from page 38)

hospital associations and hospital workers be urged to make a careful and intimate study of the whole field of health insurance and the effect such system would have upon hospital development in Canada;

(b) That developments towards health insurance in the Dominion and Provincial fields be closely observed;

(c) That the best way to insure that any social changes will be ultimately in the best interests of the people is to participate in the formulation of any such policies in their early stages rather than to keep strictly aloof from these social movements;

(d) That the possibility of various forms of voluntary insurance meeting the needs of the people, without recourse to state control, should be fully studied;

(e) That any form of health insurance which would interfere with the autonomy of our voluntary institutions (except for necessary supervision of the expenditure of trust and public funds) or which would interfere with the future development or scientific objectives of such institutions, or which would destroy the spirit of freedom and charity or would place hospitals under political control, should be strongly opposed. (Carried).

Canadian Nurses' Association

BE IT RESOLVED that this Council record its approval of the efforts which have been put forth by the Canadian Nurses' Association to provide a curriculum for schools of nursing education; furthermore the Canadian Hospital Council commends it as a basis for a revised curriculum. (Carried).

Canadian Tuberculosis Association

BE IT RESOLVED—

(1) That this Council commends and endorses the action taken by the Canadian Tuberculosis Association in its efforts to determine whether the tuberculosis risk in hospital contact is greater to those who enter nursing service as non reactors to tuberculin than to those whose reactions are positive, inasmuch as the information gathered may determine the advisability of the universal adoption of the use of B.C.G., or other immunizing vaccine;

(2) That the committee now studying the proposed new curriculum of nursing education so arrange the course that no nurse will enter the wards to give attention to any patient until such time as the school management is convinced that every nurse in training has had sufficient knowledge of communicable diseases and the dangers associated therewith that she can properly guard herself against infection.

(3) That every hospital either establish a system whereby every patient upon admission be placed on "precautions" until such a time as the attending physician certifies that the patient is free of infective tuberculosis or other communicable disease, or some form of chest service be established in each hospital for the purpose of early diagnosis of a concurrent tuberculosis. (Carried).

Cancer Control

WHEREAS the King George V. Silver Jubilee Cancer Fund for Canada has arranged a plan with the Canadian Medical Association whereby the funds available will be utilized to set up a Department of Cancer Control in the Canadian Medical Association and also a national medico-lay organization, which would give all individuals and all organizations interested in the control of cancer the opportunity to participate in this fight;

AND WHEREAS the Department of Cancer Control will set up in each organized hospital of 100 beds or over, where no tumour clinic or cancer committee already exists, a Cancer Committee for the study of cancer care in that particular hospital, to prepare extensive literature for both medical and lay education on cancer and its control, and to prepare material and organize recruits for public addresses on the subject of cancer.

AND WHEREAS hospitals are definitely interested in any cancer programme and the King George V Silver Jubilee Cancer Fund, through the Department of Cancer Control, will be requesting the co-operation of hospital facilities and hospital medical and technical staffs;

THEREFORE, BE IT RESOLVED, that the Canadian Hospital Council pledge the support of the hospitals and their facilities in this very worthy programme. (Carried).

Accounting and Statistical Returns

BE IT RESOLVED that this Council forward to the Honourable W. D. Euler, Minister of Trade and Commerce, and to the Dominion Bureau of Statistics its grateful appreciation of the very valuable and useful compilations of hospital statistics made by the Dominion Bureau of Statistics and for the publication by this Bureau of the annual Directory of Hospitals.

BE IT FURTHER RESOLVED that this Council is sincerely appreciative of the leadership and assistance given by Dr. R. H. Coats and Mr. J. C. Brady in our joint effort to produce a uniform accounting system for hospitals in all parts of Canada. (Carried).

Accounting and Statistical Forms

WHEREAS it would, at this time, appear that various provincial governments are endeavouring to strengthen, by amendments, existing regulations insofar as statistical and financial returns from local hospitals are concerned, and,

WHEREAS the Committee on Accounting of the Canadian Hospital Council has and still is studying, with the assistance of the Dominion Bureau of Statistics, the preparation of Dominion-wide reporting systems, and

WHEREAS unified statistical and financial returns for all hospitals in the Dominion are most desirable for comparative purposes,

WHEREAS, at the Conference on Hospital Statistics held in Ottawa in 1935, the representatives of the Dominion Bureau of Statistics, of all the provincial departments of health and of the Canadian Hospital Council agreed

that statistical and financial returns should be unified for all provinces,

WHEREAS, the Committee on Accounting and Statistics of the Canadian Hospital Council has prepared, with the collaboration of the Dominion Bureau of Statistics, forms which have been approved by the Canadian Hospital Council,

THEREFORE, BE IT RESOLVED, that this meeting go on record as requesting the provincial governments to adopt these forms and the principles and definitions incorporated in a set of instructions to be edited by the Committee on Accounting and Statistics, the aforesaid principles and definitions having been approved by the Canadian Hospital Council in 1937.

AND ALSO that, after agreement with the Dominion Bureau of Statistics and the Committee on Accounting and Statistics of the Canadian Hospital Council on possible improvements to the aforesaid forms, at least one year's notice should be given to the hospitals of the date on which they would be required to fill in these returns, so that ample time may be given the hospitals to establish the proper record books necessary to the preparation of such reports. (Carried).

MOTIONS

In addition to the above resolutions, the following have been selected from among the Motions passed at the Council sessions. A full report of the procedures will appear in the Transactions, to be issued at a later date.

Incorporation of Council

WHEREAS there is now in existence an incorporated body known as The Canadian Hospital Council.

AND WHEREAS the aims and objects of the said incorporated body are identical with the aims and objects of the unincorporated body known as Canadian Hospital Council.

AND WHEREAS all the members of the unincorporated Canadian Hospital Council have made application for membership in the incorporated body,

NOW THEREFORE BE IT RESOLVED, that the Canadian Hospital Council (unincorporated) be and the same is hereby dissolved, and that all records and assets including money in the bank belonging to Canadian Hospital Council, unincorporated, be transferred and handed over to The Canadian Hospital Council, Incorporated. (Carried.)

Appointment of Officers

MOVED that the action of the applicants for incorporation, in naming the old officers as officers of the new incorporated Canadian Hospital Council be approved. (Carried).

Suggested Amendment to Revised Constitution

MOVED that the incoming Committee on Constitution give early consideration to these suggestions (recommendations of the Montreal Hospital Council re Constitution), and that its recommendations be forwarded to each Council member for consideration and approval. (Carried).

Sub-Executive

MOVED that the appointment of a Sub-Executive be approved. (Carried).

International Hospital Association

MOVED that the incoming Executive of the Canadian Hospital Council be authorized to support in every way possible the meeting of the International Hospital Association and the American Hospital Association in Canada in 1939, and be asked to approach the Dominion Government for a grant of $5,000. (Carried).

Travelling Expenses Pool

MOVED that the pooling arrangement for the travelling expenses of delegates to the Canadian Hospital Council meeting be continued, as formerly. (Carried).

MOVED that overtures be made to the Federal Government to have hospitals granted similar protection as hotels and lodging houses, under the Innkeeper's Act, against persons tendering cheques without sufficient funds. (Carried).

Synchronization of Hospital Fiscal Year throughout Dominion

MOVED that the Canadian Hospital Council formally authorize the Committee on Accounting and Statistics to decide on some definite hospital fiscal year to be adopted by all provinces, to which all the Departments of Health would agree. (Carried).

Science of Purchasing

While a great deal of money can be saved in the hospital by thoughtful and economical use of supplies, it is equally important that there be an infinite amount of thought devoted to buying. There is such variety in the types of supplies purchased that the buyer must be well trained in the art of purchasing. He will be required to have on hand a sufficient quantity of varied articles ranging from mops to surgical dressings, but must arrange his buying so as not to overstock. He may be called upon to buy a small quantity of some unusual article or he may be required to purchase X-ray equipment. It is true that in the purchase of the more technical items he has the assistance of the specialists who are in charge of the various departments, but he must have sufficient knowledge to appreciate and understand advice when it is given. He is responsible, and if a costly error is made it is he who will be held accountable.

The purchasing agent must be honest, and equally necessary, he must know and depend upon reliable firms. Many times he will be tempted by an apparent bargain from an unknown dealer or from one who is known to be of doubtful integrity. If his honesty has been proved he will hesitate to reject the apparent bargain.

His contact with the representatives of reliable and established dealers is a constant source of education but it also establishes business friendship which will often secure for him very definite purchasing advantages. This is particularly true in a fluctuating market. The large business concerns are constantly in touch with world markets and are interested in securing for their customers the advantages of fluctuations insofar as they can be foreseen.

Some Comments on Small Hospitals

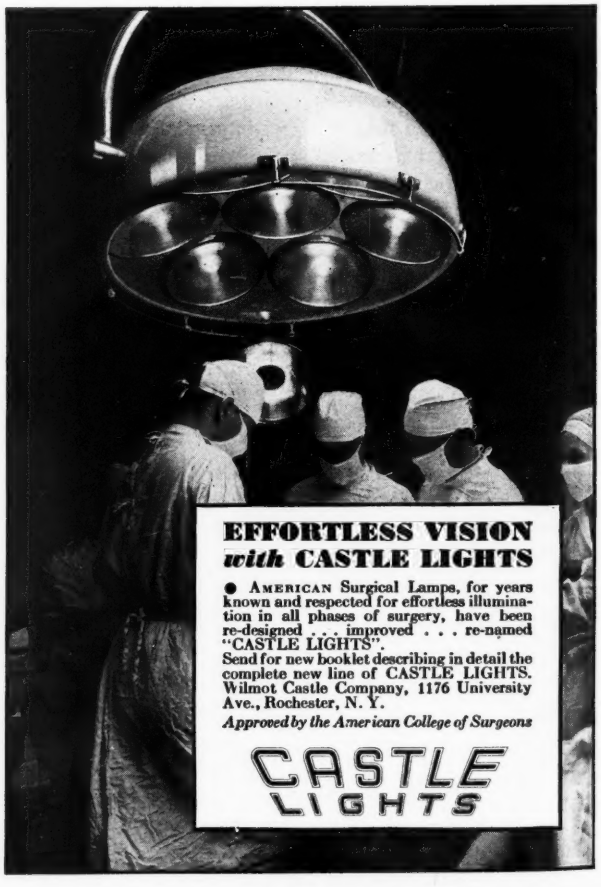
By REV. R. J. WILLIAMS, M.D.,
Boiestown, N.B.

AS every great work began in a small way, it is fitting to go back to the present day source of all hospitals, but more especially, the Small Hospital; thus we retrace our steps back over the centuries to those wayside homes of charity-minded communities, "like the Monks of St. Bernard in the Swiss Alps", ever ready to assist the sick and infirm wayfarer, or shelter the traveller on his journey, many times without reward or hope of reward, so from this humble beginning we derive the word *Hospitalis* meaning host or guest, and synonymous with this is our "hotel", which has come to mean a commercial abode, but nevertheless is often associated with community and hospital life, as our Hotel Dieu hospitals.

In our present day complex system of hospitalization, the old institutions with their simple methods of treating the sick have disappeared, with the centuries of their birth, and more modern methods have come into being through research and inventive genius, so that even the Small Hospital enjoys the many new improvements at comparatively small cost.

The Small Hospital holds a unique but very important place in the great field of hospitalization; unique, when one considers the varieties of control. The small institution must accept the means at hand and be general in its scope, accepting all cases, treating them with the available equipment and calling on experienced help or a Big Brother hospital when occasion arises.

There is a warmth of sympathetic contact between the patient and the general staff in the Small Hospital, as compared to the larger businesslike institution, whose units function with machine-like precision, and through whose doors thousands of patients yearly come and go. One might believe that it is an easy matter to open, equip and maintain a Small Hospital; this idea is not borne out by those experienced in hospitalization. They know that there are as many problems to contend with as in any large business project, and there are also many uncertainties with no guarantee of success even after years of effort and experience. However, there is a fascination about the work which appeals to the heart, because one is dealing with



human beings like himself, created through love, and this begets a like response. The motto on the Crest of the former Prince of Wales could be fittingly set over the door of any Small Hospital, "Ich Dien", I serve, for its service to suffering humanity is the highest type of service.

Financial Migraine, a chronic hospital affliction, is a serious problem, and is best treated by preventive measures after the first attack which comes through financing building and equipment; this may be lessened or overcome by soliciting funds at the outset from government, municipality and individuals. Some will give generously of advice or criticism; others will provide liberal patronage to the free bed or clinic. These are but some of the thorns in life, so let the good work go forward, for great oaks from little acorns grow.

With modern methods of canning and preserving, the Small Hospital in a country district, or which has a farm attached to its holdings, can reduce one item of upkeep, for there are so many things which can be grown in variety, quality and quantity from farm and garden, and stored away for winter and spring months. A canning outfit only costs ten dollars, and enamel-lined cans are available, so that foods are kept in perfect condition for months. Also many patrons are able to pay in produce instead of cash.

Co-operative purchasing of materials has its advantage in many respects, as a group of hospitals can arrange with a commercial house to take a certain amount of goods at a volume rate. If a certain amount be required to obtain the percentage cut, and each hospital orders according to bed capacity or number of patients, the plan should be beneficial to all, but if a certain sum be required per order or per year, it may work a hardship to the small hospital which may have supplies left from its last purchase. It also binds one to purchase from that particular firm regardless of quality, which may become inferior after trade be established, unless specifications are rigid.

Hospital Day is an opportunity for the general public to see first hand the great work that their hospital is doing. A table display of patient-made articles is a novel way to demonstrate mental psycho-therapy during convalescence. Hospital slides with a short lecture may be employed to explain the different facilities or illustrate interesting facts about diseases. An evening entertainment or hospital benefit may be staged to help furnish a free bed.

Extracted from Bulletin No. 25, C.H.C.

* * *

Les petits hôpitaux

Par Mme Beaubien de l'Hôpital Ste-Justine, Montréal.

De même que toute oeuvre de grande envergure a commencé modestement, il est à propos aujourd'hui de remonter à l'origine de tous les hôpitaux, et plus spécialement à celle des petits hôpitaux; alors, nous referons la route, suivie dans les siècles passés, par les voyageurs accueillis dans ces maion de charité, telles celles des moines de St-Bernard des Alpes Suisses, toujours prêtes à assister le malade ou l'infirme ou à abriter le passant, souvent sans récompense ou sans l'espoir d'une récompense; c'est pourquoi de ces humbles débuts nous vient le mot "hospitalis," signifiant hôte, synonyme aussi du mot

"Hôtel," qui se prend également dans un sens commercial, mais qui toutefois est souvent associé avec la vie de communauté et d'hôpital comme nos hôtels-Dieu.

Avec l'avènement des siècles et le système compliqué que nous avons actuellement, les anciennes institutions avec leurs méthodes si simples de traiter les malades ont disparu, et plus spécialement les méthodes modernes ont été adoptées à la suite de recherches et d'inventions géniales en sorte que même le petit hôpital jouit maintenant des mêmes améliorations à un prix comparativement bas.

Le petit hôpital tient une place unique et très importante dans le grand champ de l'hospitalisation, unique si l'on considère la variété du contrôle. La petite institution doit accepter les moyens à sa disposition et doit avoir un but général en acceptant tous les cas, les traitant avec l'instrumentation à sa disposition, et se prévalant de la main-d'oeuvre expérimentée d'un plus grand hôpital lorsque le besoin le demande.

Un courant de sympathie s'établit plus facilement entre le patient et le personnel d'un petit hôpital que dans une grande institution où les fonctions sont plus ou moins mécaniques, et d'ou sortent chaque année des milliers de patients.

On serait porté à croire que c'est chose facile que d'ouvrir, d'organiser et de maintenir un petit hôpital; cette opinion n'existe pas chez ceux qui ont acquis une expérienoe dans les organisations hospitalières. Ils réalisent qu'il y a là autant de problèmes à résoudre que dans un grand hôpital et qu'on y rencontre les mêmes incertitudes, sans garantie de succès, même après des années d'efforts et d'expérience. Cependant, il y a un attrait tout spécial à ce travail qui prend au coeur, étant donné que l'on soigne un être humain comme soi, créé par l'amour, et ceci fait naître une réciprocité de sentiments.

La devise sur les Armoiries de l'ex-Prince de Galles serait appropriée à tout petit hôpital "Ich Dien," "je sers" vu que le service rendu à l'humanité souffrante est des plus nobles.

Le souci financier, affliction chronique dans un hôpital, est une sérieux problème. Il est plus efficacement traité par des mesures préventives dès la première attaque qui provient du problème de la construction et de l'installation en général. Cette difficulté peut être amoindrie ou surmontée en sollicitant dès le début des fonds soit du Gouvernement, de la Municipalité ou de l'individu. Les uns donneront généreusement des conseils ou des critiques; d'autres accorderont leur patronage aux cliniques et aux indigents. Ces difficultés ne sont que des épines dans la vie, laissez donc "le bon" aller de l'avant, car les petits ruisseaux font les grandes rivières."

En employant les méthodes modernes de conserver les fruits et les légumes qui peuvent être cultivés en grande quantité et nombreuses variétés et mis en réserve pour les mois d'hiver, dans les centres ruraux, ou encore en ayant une ferme attachée à ses dépendances un petit hôpital, peut réduire ses frais d'entretien de façon considérable.

Le coût d'un appareil servant à la préparation des fruits en conserve n'est que de $10.00; et l'on peut se

procurer les boîtes à conserves qui sont émaillées à l'intérieur de façon à conserver les aliments en parfait état pour plusieurs mois. En plus, ceci procure au petit hôpital l'avantage d'obtenir des dons en nature de la part de bienfaiteurs.

L'achat en gros d'approvisionnements a ses avantages à plusieurs points de vue, car un groupe d'hôpitaux peuvent s'entendre avec une maison de commerce pour obtenir une réduction sur un montant considérable d'achats. Si un certain montant d'achats est requis pour obtenir un rabais et que chaque hôpital place une commande selon son importance et sa capacité d'hospitalisation, ce plan devrait être avantageux pour tous; mais si un certain montant est requis par commande, ou par année, il pourrait devenir onéreux pour le petit hôpital qui aurait alors un surplus d'approvisionnements.

"Hospital Day" est une occasion pour le public en général de constater le travail considérable et important qui se fait dans les hôpitaux. Une exposition d'articles confectionnés par les patients convalescents est un nouveau moyen de démontrer l'avantage de la psychothérapie durant la convalescence.

Les pellicules illustrant les différentes méthodes de traitement employées à l'hôpital peuvent être doublement intéressantes si elles sont accompagnées d'explications. Une soirée récréative peut être organisée avec avantage en vue d'obtenir le maintien d'un lit.

The Edmonton Dietitians Reporting Club

A reporting club—undoubtedly it would have something to do with a newspaper—but no, you're wrong—the majority of its members have not time to read a newspaper let alone report for one.

The membership of this club is composed of dietitians employed in Edmonton Hospitals and is limited to fifteen. Why fifteen? Because that's a cosy number to form a discussion group.

And by that last statement we have given you a clue to what we do. We report on all the latest journals, medical, commercial and dietetic, weed out all the extraneous material and present to the club all the latest knowledge in our field. In this manner even the wild and woolly westerners are able to keep up with the "March of Time."

And since we're dietitians, it's only natural that our meetings should be supper ones. So to start our Club we went under the sign of the Swastika and had a German dinner in a quaint German hotel. The only German thing lacking was beer, but dietitians realize that it is fattening and obesity is — — — Oh!

Pariotism was evident at our next meeting when we dined a la Canadien. Our third meeting was in a characteristic Chinese restaurant where we feasted (try it with chopsticks ! ! !) on chow mein and china tea.

And so, on with our parade of meals. We like the idea of these get-to-gethers. We feel that we have much to share and learn and we have found this a delightful and pleasant way of doing so.

PUBLIC RELATIONS

MANY of the general subjects usually grouped under this heading have been so fully and effectively treated elsewhere that this Committee has been of the opinion that it could best serve the needs of our hospitals in Canada by making a study of the actual relationship existing between hospitals and their community in various parts of Canada. With this has been combined a study of the extent to which our hospitals are meeting the needs of their respective communities. This data has been obtained from various sources including both individuals and hospital and other associations, and in large part by actual reports of the situation in a large number of representative areas, both rural and urban.

Are Our Hospitals Meeting the Needs of the People?

It is our impression that, on the whole, our hospitals are meeting the needs of the people fairly well. Their failure to do so completely is not so much the fault of the hospitals as it is the lack of feeling of responsibility for the development of a complete service on the part of the public and also the lack of adequate legislation to effectively put into operation many of the features which our hospital workers would desire to see instituted.

Advantages and Disadvantages of the Present Public Hospital System in Canada—The System in Canada of providing hospital care for the general patient is often contrasted with insurance schemes adopted elsewhere. The *disadvantages* are as follows:

1. Costs to the paying patient are high. Not only must he pay for his own maintenance and other costs, but he bears a share of the cost of the indigent patient as the combined provincial and municipal grants do not equal the average cost of maintenance for public cases and the hospitals must keep deficits down.

2. The costs come at a time when the breadwinner, if stricken, can least afford them.

3. Hospitals are imposed upon. The municipalities may refuse to admit that the patient is a "resident" of that municipality; they may deny that he is an indigent. Private patients often leave without paying their accounts.

On the other hand, the *advantages* of the system followed here are as follows:

1. Nobody suffering from any of the complaints which come within the general hospital field is ever turned away because he has no money, or does not belong to a society, or has not had his papers properly signed by some official.

2. The hospitals are freed from bureaucratic control. They are operated in a manner most likely to best meet the local problems.

3. Patients can retain their family physician in most instances—a highly desirable feature.

4. Philanthropy is encouraged and sympathetic public interest is stimulated.

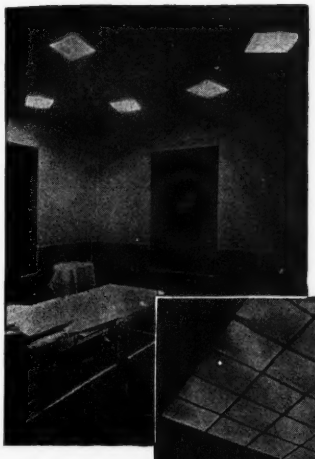
Perhaps the greatest problem, at least in so far as it is brought to the public mind, is the difficulty of bringing diagnosis and all hospital care within reach of the average purse. Patients do not always know in advance of illness or accident and even when they do anticipate such an event their budgetting is seldom sufficient. Many factors are responsible for this unhappy situation; human life is being salvaged more than ever before and the cost of achieving this desirable object is steadily mounting; people are living beyond their means and have their futures so mortgaged by instalment buying that there is nothing left for the emergency.

A general survey of our rural districts would indicate that, on the whole, they served comparatively well. It is true there are vast areas of scattered population in the hinterland where general hospital service is quite distant or utterly lacking, but if we consider under the heading "rural areas" our chief agricultural districts, the majority of these have reasonably good hospital accommodation. This is becoming more so with the establishment of small local hospitals and with the annihilation of distance by better roads and the motor car. Too much credit cannot be given to the Red Cross Society for its establishment of outposts, to the various religious bodies which have established hospital and medical missions in our newer areas and to the enterprise of rural settlers who have banded together to establish small local municipal and in some cases, union hospitals. Undoubtedly many more of these could be established were funds available and greater efforts should be made to develop these small institutions in areas where they are necessary. However, a warning note should be sounded. Because of local pride, sometimes because of district jealousies, because of religious differences, several small closely adjacent communities establish tiny hospitals in competition with each other, serving the same area, duplicating overhead and expenses, and yet none of the competing hospitals provide anything like the diagnostic and therapeutic facilities which would be possible were their resources pooled.

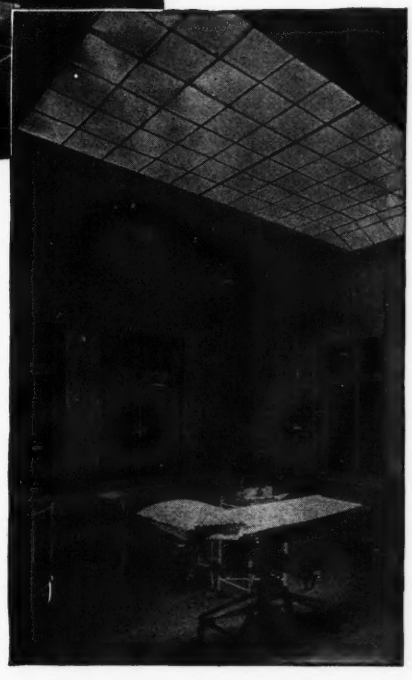
Competition is Often a Detriment

Competition between hospitals in medium-sized or larger communities may be beneficial in that each tries to attain a high level of efficiency but in so many communities or districts where there is a whole chain of hospitals within a few minutes driving distance of each other, such effort is grossly wasteful.

A further doubtful feature of certain small hospitals is that they undertake diagnostic and therapeutic procedures for which they are not properly equipped. Sometimes equipment such as full X-ray equipment or physiotherapy or laboratory equipment may be installed but there is no one on the staff sufficiently skilled to fully utilize this equipment or with sufficient turn-over of cases and resultant experience to maintain the skill of early training. The opinion is frequently expressed that improperly



DELIVERY ROOM.—This installation comprises 5 Holophane lens boxes set flush with the ceiling and each fitted with 150-watt lamp. The light is directed to suit the specific requirements of this room.



MAIN OPERATING ROOM.—Installation consists of a Holophane lens system set flush with the ceiling and equipped with 21 150-watt lamps. Lamps are so wired that light can be obtained dominantly from the side or from either end as required.

LIGHTING for Hospitals

Dependable, scientifically-arranged lighting is a necessity in the modern hospital. The new Halifax Infirmary is an outstanding example of how electricity has been made to serve humanity, and Northern Electric is proud of its part in this instance. Northern Electric engineers are familiar with the illumination problems confronting hospital authorities. They will gladly co-operate with *you* in overcoming *your* difficulties.

20 branches from coast to coast.

21-22R

Northern Electric
COMPANY LIMITED
A NATIONAL ELECTRICAL SERVICE

Sister Superior's Office and Board Room, St. Michael's Hospital, Toronto.

HEES VENETIAN BLINDS

are used at the windows of the new addition at St. Michael's Hospital, Toronto.

The hospital, more than any other building, requires uniform lighting, efficient yet without glare. HEES VENETIAN BLINDS are specified to solve the problem of the vagaries of daylight in many of Canada's largest and most modern hospitals . . . too strong sunshine can be diffused to a softened indirect illumination, and grey days made cheerful by deflected light rays. JUST BY THE TURN OF A CORD, WITH HEES VENETIAN BLINDS YOU CAN ADJUST DAYLIGHT.

Easily kept immaculately clean.
Reliable, simple of mechanism, hygienic in appearance.
More than twenty lovely colours in slats and ladder tapes.

Write for colour chart and illustrated folders. Our more than sixty years' experience of equipping Canadian windows in homes and public buildings is at your service.

Sold by leading house furnishings stores and interior decorators.

MANUFACTURED AND GUARANTEED BY

GEO. H. HEES SON & COMPANY LIMITED

TORONTO **MONTREAL**

utilized, highly technical equipment and procedures may be a greater menace than a blessing to the community.

However, these observations should not be construed as opposing the set-up of small hospitals where the district is not adequately served by adjacent hospitals nor as opposing the utilization by such small hospitals of routine laboratory procedures or of a portable or small X-ray equipment for emergency fractures, etc.

What Facilities Have Been Provided for the Care of the Incurable, the Chronically Ill?

It is difficult to estimate exactly the hospital accommodation available for such patients as some hospitals, particularly in the Province of Quebec, have wards available for such patients. However, a survey of special accommodation for the incurable and the chronically ill patient would indicate that, if we exclude Quebec for which province this data is not available we have only about 2,100 beds for this type of patient. These institutions are located apparently in but fifteen centres.

These hospitals fall far short of meeting the actual demand, especially in those cities and towns without such institutions. In some institutions it takes three or four months or longer to obtain admission. Practically all of our general hospitals harbour varying numbers of patients who have become chronic or are incurable and who would be housed elsewhere were such special hospitals available or not overcrowded. This frequently means that acute cases find difficulty in getting into general hospitals and usually means a loss to the hospital for in many provinces the grant is reduced or discontinued after a certain period, and instances are known where chronic cases have been kept in public hospitals for months and even years, frequently at a total loss to the hospital, because there was no place else for the patient. In addition many incurable patients must be kept at home, where hospital accommodation is lacking, and this often causes additional suffering from lack of proper care and frequently considerable inconvenience and hardship to relatives.

Are There Sufficient Reception Hospitals for the Early Mental Cases?

There is a general lack in Canada of sufficient reception hospital accommodation. On the whole Canada is well supplied with mental institutions, but these hospitals do not meet the needs of the mildly demented patient who requires observation for symptoms which may be physical rather than mental in origin and who should not be subjected, nor should the family, to the embarrassment of detention in a mental institution. Also it may be straining a point for the physician to certify such patient to be "insane" and yet the relatives (or the general hospital) must be relieved of the burden of caring for such irrational patients. Some hospitals, as for instance, the Regina General Hospital, have established Psychiatric Wards wherein patients may be kept for a certain period of observation. More general hospitals might undertake this service were it possible to receive adequate remuneration to cover the increased cost of providing attendants and precautionary safeguards. Also some cities, for example, Toronto, have established reception hospitals to which patients may be admitted for observation without the ritual and formality required for admission to regular mental institutions.

What Criticisms of Our Hospital System are Most Frequently Encountered?

This is considered somewhat in earlier sections, but the chief criticisms may be recapitulated here:

(a) Financial burden at time of sickness too high on average individual.

(b) Present hospital system designed for the poor and for the wealthy.

(c) Hospital provision incomplete. Many diseases not adequately provided for.

(d) Diagnostic services too expensive.

(e) Hospitals lack a strong financial foundation. Endowments unknown in most hospitals. Municipal and provincial grants, although generous, insufficient to prevent deficits.

(f) Lack of sufficient supervision in some hospitals of the work done therein by medical practitioners.

(g) Conversely, the criticism is also expressed that many medical men are restricted in their use of hospital facilities.

(h) Overlapping of districts, two or more hospitals serving the same district.

(i) Lack of "personal touch" and sympathy on the part of many of the hospital personnel.

(j) Business efficiency. Criticisms here are contradictory. Hospitals are said to be too business-like and mercenary in demanding payment by patients and on the other hand, municipal authorities state that their deficits are often due to lack of good business principles in collecting accounts, in demanding efficiency, etc.

(k) Doctors complain bitterly that they are badly imposed upon by being requested constantly to attend patients in public wards and outpatient departments without remuneration, as well as caring for their free patients in private practice. Moreover, they are the first ones called upon to subscribe to any new hospital construction. Doctors give a great deal of time to the training school without remuneration.

(l) Many patients feel that their hospital care should include full nursing service and that they should not be compelled to employ "specials."

(m) Paying patients object to having to pay not only for themselves but for part of the maintenance of the indigent patients. This is due to faulty legislation.

(n) In the hospital itself patients are antagonized against hospitals very often by such details as noise, "hospital smells," press reference to hospital accidents (. . . . died following an operation"), gossip by pupil nurses and their seniors and other factors.

How Should These Criticisms be Met and the General Public Interested in Our Hospitals and Their Work?

All criticisms which are based upon misapprehension should be corrected as far as possible. This is a stupendous task because the public loves to misunderstand its benefactors, but the various avenues of publicity, particularly the spoken word of hospital workers should be utilized as far as possible.

Criticisms which are well founded should be taken seriously and every effort made to eliminate offending factors or supply the missing services. This can be accomplished only by:

(a) Free discussion of these criticisms in hospital conventions and at board and staff meetings in the individual hospitals.

(b) Crystallation of opinion throughout the provinces so that some uniformity of action may be possible. Enlistment of public and legislative sympathy so that sufficient financial support may be forthcoming to overcome many of these criticisms.

(c) Elimination of local jealousies and rivalry to permit such factors from beclouding the main issues.

(d) A serious study and analysis of our own and other hospital systems so that, if our hospital system is not the ideal one, we may adopt from other systems and experiences elsewhere those features which will make our own hospital system best serve our public.

Where the services to the public are not complete local hospitals or local hospital councils or associations should form public relations committees which will, through the press, by pamphlet and by personal effort, educate the people and the government and the municipal authorities of the necessity of providing more complete services than at present. The usual criticism for such deficiencies is levelled at our hospital leaders and workers who really have nothing to do with the problem of rounding out the services. After all, it is a financial problem and such workers would be only too glad to develop the services needed, provided the public at large supplied them with the necessary finances.

It is true some criticism might be levelled at our trustees and our medical staffs in that they do not undertake, as citizens, more definite leadership in demanding that the public, through their municipal and provincial legislators, support the needed innovations. Medical men are prone to become submerged in the onerous duties of their practice; they find that looking after the interests of their individual patients takes all their attention and their multitudinous gifts of time and skill to their charity patients, both in the hospital and in their homes, comprise more than an average share of public responsibility. Nevertheless, as public-spirited citizens, they have an excellent opportunity of taking the lead in health work.

And so with the trustees. While many trustees devote a great deal of their time and thought in helping the hospital and the community at large, many others have very little grasp of the health needs of the community and in fact, beyond attending board meetings, take very little interest in the development of their own hospitals. Where hospitals are blessed with wide awake, alert and progressive trustees and staff members, much is being done to improve the general health of the community by meeting the needs of the citizens in as many ways as possible.

Women's auxiliaries, aids and societies should be developed as much as possible.

The Red Cross Society which has done so much to develop hospitals in scattered communities should be supported by the public at large and given every encouragement and assistance by hospital workers in more settled communities.

Co-operation—If hospitals are going to prevent overlapping, duplication of services, wasteful overhead and neglect of large areas, it will be essential that we have infinitely more co-operation between hospitals than we do at present. The present haphazard method of building hospitals upon the whim or enthusiasm of individuals or upon the basis of local municipal pride or jealousy must cease if hospitals are to hold the enthusiastic support of our intelligent citizens.

Co-operation and joint effort is the order of the day in big business and it has been justified in increased efficiency with decreased operating costs. Much could be accomplished if our several institutions in larger centres could co-operate in the utilization of certain facilities and highly skilled assistants, in co-operative purchasing, etc. The lessons of the war might be applied by the development of a closer relationship between large city hospitals with full diagnostic and therapeutic facilities and small hospitals in neighbouring towns with good roads and rapid transit and telephone. Many features of the base hospital-casualty clearing station arrangement could be adopted. All of the existing hospitals could still be utilized and there would be no reason why the same groups operating hospitals should not continue to do so. The only difference would be that the action of all concerned would be co-ordinated. Such co-ordination would be very difficult as hospitals are maintained at the present time and it may only be possible under more extensive provincial government jurisdiction over hospital activities and development than at present. However, as hospital expenses rise and as the share of municipal and provincial responsibility for hospital support increases, it is very likely that the government, being responsible for so much financial support, will, with some justification, demand that it have a greater say in the scope and direction of hospital activities.

What Consideration Has Been Given to Periodic Health Examinations for Those Unable to Pay?

Very little has been done as yet for the organization of periodic health examination clinics for those unable to pay. Some time ago the Canadian Medical Association organized a sub-department dealing with this matter for a one year experiment which was conducted with the co-operation of a number of insurance companies. An educational moving picture film was prepared, literature was written and a very fine Periodic Health Examination form was drafted and endorsed by the Association. Certain groups of policy holders of the various insurance companies were entitled to these free examinations. At the end of the year a Canadian Medical Institute was formed, separate and apart from the Canadian Medical Association, which is now carrying on this laudable work of arranging physical examinations of the policy holders of these insurance companies.

This of course, does not meet the needs of those unable to pay. The logical place to have such examinations made is in the out-patient department of the hospitals, but it it very obvious that such examinations, which are quite time-consuming if properly done, would constitute a considerable imposition upon the medical staffs of the hospitals and, considering the tremendous load of unremunerative service already performed by the profession, it is doubtful if their co-operation could be expected unless their services were remunerated to some extent. One doubts if the federal or provincial governments could be called upon to do very much in this respect and the present sources of revenue would seem to be the municipal or

community chest. In Vancouver the Council of Social Agencies has accomplished much in the promotion of this work.

If unemployment insurance comes in, as it may, the problem would be simplified in that such services might be considered a legitimate call upon the funds of such insurance, particularly if it were linked up with some form of health insurance.

Pay Diagnostic Clinics

By "pay diagnostic clinics" is meant a clinic which will give a complete diagnostic service, usually for a set schedule of moderate fees, the patient being referred back to the private physician for treatment. These clinics have not been established to any extent in Canada. However, there is considerable discussion of this possible development because the increasing complexity of our diagnostic methods makes it exceedingly difficult for so many individuals to pay the charges which must be made to permit private physicians to provide these expensive services. It is possible that concentration of these services could be effected to reduce overhead, provide better diagnosis and not interfere with that personal relationship between patint and physician which is so essential.

While the "tonsil clinics" operated by the province of Alberta do not entirely come under this category, as here defined, nevertheless in a broad sense they may be considered diagnostic clinics inasmuch as many people have gone to these clinics for examination for various complaints.

In September, 1928, a conference of interested parties was held in Saskatoon, Saskatchewan, and the government was requested to make an investigation relative to the formation of a free diagnostic clinic in that province. It was suggested that diagnostic clinics be tried in connection with existing institutions equipped to give full diagnostic service; that the work be done by the doctors on the staffs of these hospitals, that all cases have a case history and provisional diagnosis from the attending doctor and that the findings be referred back to such doctor. It was recommended that the examination costs be defrayed by a pooling arrangement to be devised by the Department of Public Health, the interested hospitals and the interested rural and urban municipalities.

It was pointed out at that time that this arrangement would not cost very much as existing institutions could be used; every physician would have a part in diagnosing his own cases and would maintain contact with his patients. Private practice would be maintained, the patient would still have his own physician and there would be no costly duplication of costly apparatus. The advantage of such an arrangement over the travelling clinic is obvious as it is impossible for all necessary equipment to be carried to the patients' own bedside in the rural home. It would be necessary to emphasize that the hospital makes the examination and that the relationship between the patient and the doctor at the clinic be more or less impersonal. The examining doctors could maintain the full cooperation of the private practitioners by insisting upon a letter from the family doctor and upon the patient returning to the family doctor for subsequent treatment.

In Ontario there are travelling chest clinics (as in some other provinces) and these have done a great deal of diagnostic work wherever they have gone, but the financial factor is not an essential one, nearly all examinations are made free of charge.

Hospitals are interested in this possible development because the logical place for such diagnostic clinic would be one of the local hospitals. Obviously this development is only possible in communities of reasonable size and care should be taken to ensure the enthusiastic support of the medical profession.

Report of the Committee on Public Relations of the Canadian Hospital Council, Winnipeg, published as Bulletin No. 8.

Editor's note—This article is comprised of extracts from the very valuable report of the Committe on Public Relations under the Chairmanship of Rev. R. J. Williams, P.P., M.D. A great deal of abbreviation has been necessary as the report is quite lengthy but interested readers who have not the complete report on file may obtain copies from the Canadian Hospital Council, 184 College Street, Toronto.

Poliomyelitis Care Being Expedited

It is gratifying to note the efforts being put forth by the Ontario Department of Health to combat the epidemic of infantile paralysis, which has become so serious in this province. Already some 1,500 cases have been reported. Convalescent serum has been made available to all doctors making application for it. The Government has also distributed to all doctors a booklet containing the papers making up a symposium on "Anterior Poliomyelitis" presented at a special meeting of the Toronto Academy of Medicine in September, and reprinted from the September issue of the Canadian Public Health Journal.

Splints and Bradford Frames Available

The Department has also arranged that splints and Bradford frames may be secured at its expense for any cases which are not now receiving this type of treatment. Furthermore, the Department is providing a limited period of care in hospital free of charge for all such cases. This period of from one to three weeks in hospital following isolation is being provided in order that patients may learn to adapt themselves to the proper use of the Bradford frame and necessary splints. Hospitalization and the provision of frames and splints are available at Toronto, Hamilton, Windsor, London, Ottawa, Fort William, Kingston, Sudbury and Sault Ste Marie.

During the latter part of September the former Grace Hospital in Toronto was taken over by the Government as a special orthopedic hospital. This hospital has been used as a nurses' residence since the amalgamation of Grace Hospital with the Toronto Western Hospital, and will make a well-located building for the reception of paralysis cases. It has been announced that Doctor D. E. Robertson, Surgeon-in-Chief of the Hospital for Sick Children, Toronto, will be Chief of this new Orthopedic Hospital.

Special Diets Used in Neurological Cases

By H. M. KEITH, M.B.
Neurological Institute, Montreal.

AT the Montreal Neurological Institute, the diets in general use are those of the Royal Victoria Hospital, and for most purposes there is little deviation from these. There are one or two factors, however, which should be emphasized. (1) High calorie diets are used to a considerable extent as the patients are very often in need of extra nourishment. (2) There are large numbers of surgical cases constantly in the Institute and in one point their diets differ from those in the usual surgical wards, namely, that the patients can eat a soft or even a full diet a short time after operation. Frequently within twenty-four to forty-eight hours, soft foods can be given readily and can be followed within a day or so by a full diet. This is understandable because most patients have operations elsewhere than on the alimentary tract. The one factor tending to cause disturbance is the anaesthetic and frequently this is local only, causing still less disturbance in the gastro-intestinal tract.

Department of

The Canadian Dietetic Association

Conducted by Ruth Davidson Reid, B.A.

James A. Ogilvy's Limited, Montreal

There are, however, several special diets in use for specific purposes. The first of these, and one of the most commonly used, is the ketogenic or high fat, low carbohydrate diet. This is of particular benefit in treating children with epilepsy, chiefly that type of epilepsy that is called idiopathic, in which no surgical intervention is necessary. A ketogenic diet, to be effective, must be rigidly controlled and should be a weighed diet. I have always felt that the assistance of a dietetian is necessary in carrying out this diet properly. The diet is constructed in such a way that the "fat" or ketone-producing material is in the ratio of at least 3:1 with the carbohydrate or anti-ketogenic material. This ratio is calculated in the following manner: the ketogenic material consists of 90% of the fat and 46% of the protein; the anti-ketogenic material consists of all of the carbohydrate plus 58% of the protein and 10% of the fat. The ketogenic, anti-ketogenic ratio must, then, be at least 3.1 or greater. This will produce the desired effect, namely, the presence of ketone bodies in the blood and in the urine. To construct such a diet we estimate the number of calories necessary for the individual. For children, this will be fifty-five calories per kilogram or twenty-five calories per pound of body weight. The amount of protein is set at one gram per kilogram of body weight, which has been found quite satisfactory. The carbohydrate and the fat are then adjusted so that the ratio is as indicated and the calories are satisfactory for nutrition and growth. The caloric requirement is based upon the estimated weight for height as given for an eight-year-old child, whose estimated weight is fifty-five pounds or twenty-five kilos.

Boy—8 years—55 lbs. (25K)
Calories—1375
(25 cals. per lb. body wt.)
(55 cals. per kg. body wt.)

	C gms.	P gms.	F gms.	cals.	K AK
1st day	50	25	119	1371	1.5
2nd day	35	25	126	1374	2.0
3rd day	20	25	133	1377	2.7
4th day	15	25	135	1375	3.1

You will see that over a period of four days, the carbohydrate in the diet decreases rapidly and the fat increases. This is advisable because most children, placed immediately on the final diet, will become nauseated and sometimes will have severe vomiting. However, with the plan indicated this very seldom occurs. In order to make certain that the patient is in ketosis, a urine test for diacetic acid is done on the first morning specimen daily. This, the patient's mother can be taught to do quite readily. Patients must be kept on this diet, in ketosis, for a period of six to twelve months. The carbohydrate in the diet is then gradually increased and the amount of fat reduced until the diet is essentially normal again. This usually takes place over a period of three to six months. About one-third of the children treated with this diet become free from epileptiform attacks and remain free for a long period—perhaps permanently. Because of this, it is felt that the diet is important and well worth the difficulties encountered. For an adult, the diet is the same in principal, although the caloric demand and the amount of protein necessary is different. The results in adults are not so satisfactory as in children; therefore, it is used mainly for children under fifteen years of age.

The next specific type of diet is the high calcium diet. This is used particularly in cases of lead neuritis or lead poisoning of any type. The rationale of this type of diet is as follows: the metabolism of lead is very similar to that of calcium; it is probably carried in the blood stream as colloidal lead phosphate, and it is deposited in the bone tissue as tertiary lead phosphate. This is a non-toxic form and is quite inert. Causing excretion of lead is harmful to the patient to a considerable degree. Our effort, then, is to precipitate the deposit of lead and calcium in the bones, where it does little or no harm. Once it has been deposited in the bones it may be excreted in very small amounts over long periods without causing any real disturbance. To accomplish this result, we then use diets high in calcium.

(Continued on page 74)

DOCTORS are giving increasing attention to the importance of foods in maintaining physical well-being. Unbalanced, faulty diets—long continued—can lead to many ailments.

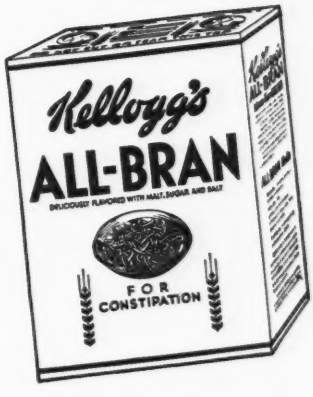
A common fault of our present-day, highly refined foods is lack of sufficient "bulk." Too often, as a result, common constipation develops.

This condition can be relieved by adding a natural laxative food to the average menu. Kellogg's ALL-BRAN supplies helpful "bulk," as well as vitamin B to help tone the intestines, and iron for the blood.

Within the body, ALL-BRAN absorbs at least twice its weight in water, forms a soft mass, gently exercises and cleanses the system.

ALL-BRAN may be served as a cereal with milk or cream, or cooked into muffins, breads, etc. Sold by all grocers. Made by Kellogg in London, Ontario.

Kellogg's
ALL-BRAN



Some of the most important food stuffs in these diets are: cheese, whole or skimmed milk, butter, egg-yolk or whole egg, cauliflower, and spinach. There are other foods, of course, that may be used but these are among the more important. The values may be obtained by reference to any standard table of food values, such as Sherman's. To this diet, we add dicalcium phosphate to increase the deposition of the lead and calcium phosphate in the bones. Vitamin D as viosterol should also be given to assist in the deposition of both these salts. An example of a high calcium diet would be as follows:

Breakfast: Orange or other fruit, fresh; cereal, preferably oatmeal; one egg; brown toast or whole-wheat muffin; butter; cream, and one glass of milk.

Dinner: Meat, fish, or chicken, particularly fish; any of the fresh vegetables, particularly cauliflower, peas, beans, spinach, etc.; potato; brown or whole-wheat bread; butter; milk; fresh fruit; milk pudding, custards, etc.

Supper: Meat or fish or chicken, or egg in some form; salad of fresh fruit and vegetable; brown bread or bran muffin; butter; milk; dessert as at dinner; cheese.

Milk up to one quart should be used daily and as many cheese and egg dishes as possible, because these have high calcium content. To increase the quantity of milk, this may be given between meals. This is not really a difficult diet to administer.

Another interesting and useful diet is the neutral low sodium diet given to patients with Meniere's syndrome. This syndrome consists of recurring dizzy attacks in which the patient is usually perfectly well between attacks. It may be unilateral or bilateral. There is some degree of deafness and tinnitus in the deaf ear. This may be treated surgically but may also be treated by means of the low sodium diet proposed by Furstenberg. When the sodium is eliminated from the diet, the patient is given ammonium chloride in capsule form. In some cases this has proved very satisfactory treatment. With this diet the protein is unrestricted; the calories must, of course, be sufficient. The low salt content is obtained by (1) the elimination of salt in cooking or at the table, by the use of salt-free bread, crackers, butter, etc.; (2) the elimination of a number of foods which are high in sodium, for example, bacon, salt pork, bananas, baking soda, beef, ham, oysters, etc. About forty-five grains of ammonium chloride are given three times daily with the meals. This can be given over long periods of time without deleterious effects.

For some time an hydration diet was used as a test diet for epileptics. This consisted of food which was mainly water. With this, injections of pitressin were given subcutaneously. Such a diet consisted of grapefruit, applesauce, cream, sweet chocolate, and water; very little else. More recently it has been found satisfactory to give pitressin, large amounts of water, and a general diet with emphasis on the vegetables and the carbohydrate foods. Pitressin causes the retention of water in the tissues. A diet high in carbohydrate does the same to a less extent. With this combination, we have been able to produce epileptiform attacks almost at will, in order to study the type and the pattern of the attack.

As was mentioned in the beginning, high calorie diets are used quite frequently in neurological cases. These patients often come to us considerably emaciated and for them we use a diet of above twenty-five hundred calories. This type of diet is probably well known, and it is understood to be a rather general diet with emphasis on cream, butter, carbohydrate foods, eggs, and meat, chicken or fish. Perhaps the most important point is that intermediate nourishment is given as frequently as possible, extra milk, cocoa, vitone, egg-nog, malted milk, or orange juice and sugar.

There is one other diet that is used occasionally in our work and that is the low purin diet. This consists mainly of cereal, milk, certain vegetables, fruit, and other carbohydrates with the elimination of meats, particularly liver, pancreas, kidney, beef, soup, tea, cocoa, coffee, and dried peas and beans. Such a diet would consist of:

LOW PURIN — LOW CREATININE
P. 50 gms. F. 100 gms. C.H.O. 175 gms.

Breakfast	Gms.	Dinner	Gms.	Supper	Gms.
Cornflakes	15	Eggs	2	Am. Cheese	40
Milk	100	Butter, fried	10	Crackers	20
Bread	20	Carrots	100	Corn	100
Butter	8	Bread	20	Milk	100
Postum	2	Prunes, A.P.	30	Fr. Tomato	150
Sugar	12	Postum	2	Grapefruit	100
Cream	40	Sugar	10	Postum	2
Orange juice	100	Cream	40	Sugar	10
				Cream	40

It is used mainly in cases of muscular dystrophy, where it is combined with glycine which may be given in the form of gelatine. This has not proved to be a very satisfactory treatment, and is being used very occasionally only.

*Presented at the Annual Meeting of The Canadian Dietetic Association, Montreal, May 28th, 1937.

* * *

Meeting of Directors held on September 18th.

A special meeting of the Directors of the Canadian Dietetic Association was held in Toronto on September 18th. The resignation of the President, Mrs. Edmund T. Guest was accepted with great regret and the following officers were elected for the ensuing year:

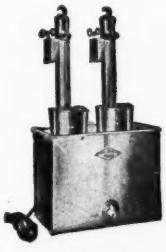
Honorary President—Annie L. Laird.
Honorary Vice-President—Frances McNally.
President—Ruth M. Park.
President Elect—Winnifred Moyle.
Vice-President—Irene Carpenter.
Recording Secretary—Charlotte Large.
Secretary-Treasurer—Kathleen Jeffs.
Directors—Helen Bates, Kathleen Guest, Grace Sharp.

BROILERS

GRIDDLE

STOCK KETTLES

AUTOMATIC WAFFLE BAKER



AUTOMATIC
EGG BOILER

Hospital Cooking Equipment

For Every Need

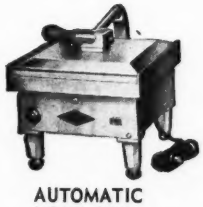
BAKE OVENS

AUTOMATIC
HEAVY DUTY RANGES

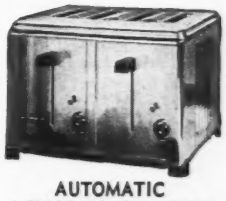
REGARDLESS of what your cooking problem may be, General Electric Cooking Equipment will do the job better and more conveniently. You'll find that these devices achieve high standards of cleanliness and speed, economy and safety. Foods cooked this modern electric way taste better, too . . . patients are kept satisfied.

Our engineers will gladly co-operate with you on planning or remodelling your kitchen to include General Electric Commercial Cooking Equipment. Send coupon today for full information.

ROASTING OVENS



AUTOMATIC
MEAT GRILL



AUTOMATIC
4-SLICE TOASTMASTER

AUTOMATIC
CONVEYOR TYPE
TOASTER

VACULATOR COFFEE MAKERS

HOT FOOD RECEPTACLES

AUTOMATIC
COUNTER FRY KETTLE

CANADIAN GENERAL ELECTRIC COMPANY LIMITED

Vancouver Calgary Winnipeg Toronto Ottawa Montreal Halifax

Canadian General Electric Co. Limited,
212 King Street West,
Toronto, Ont.

Please send information completely describing G-E Commercial Cooking Equipment for hospitals.

Name .....

Address .....

PDT-107

Programme of O.H.A. Convention

October 20th, 21st, 22nd, 1937
Royal York Hotel, Toronto

First Day, Wednesday, October 20th

Morning Session:

9.00 a.m.—10.30 a.m.—Registration.

10.30 a.m.—Report of Secretary-Treasurer, Dr. Fred W. Routley.

10.45 a.m.—Appointment of Nominating Committee.

11.00 a.m.—Official Opening of Exhibits.

12.30 noon—Luncheon. Speaker, Dr. Basil McLean, Past-President, American College of Hospital Administrators, Superintendent, Strong Memorial Hospital, Rochester, N.Y.

Afternoon Session:

2.30 p.m.—Open session conducted by Nurses' Section.

Miss Margaret Conrad, B.A., R.N., Professor Nursing, Columbia University; "Supervision of Nursing Services."

Miss Jessie Wilson, R.N., Superintendent of the Memorial Hospital, St. Thomas; "How a Nurse can Help Control Hospital Costs."

Mr. R. A. Holmes, Toronto Western Hospital, "Physiotherapy and Massage."

Evening Session:

Meetings of Sections.

* * *

Second Day, Thursday, October 21st.

Morning Session:

Chairman—Mrs. O. W. Rhynas,
President, Women's Hospital Aids.

9.30 a.m.—Miss Ethel Cryderman, President Registered Nurses' Association, "What the Registered Nurses' Association of Ontario is Attempting."

10.00 a.m.—Miss Edith F. R. Insole, Supervisor of Social Service Department, Hamilton General Hospital, "A Survey of the Work Accomplished by the various groups of volunteer women, with the Hospital Auxiliary to Hamilton General Hospital."

10.30 a.m.—Miss Florence H. M. Emory, Assistant Director, School of Nursing, University of Toronto, "Health Service in the Community."

Afternoon Session:

Chairman—Mr. David Williams,
Trustees' Section.

2.30 p.m.—Dr. Harvey Agnew, Secretary-Treasurer, Canadian Hospital Council, "An Observer Looks at Group Hospitalization."

3.00 p.m.—Dr. T. C. Routley, Secretary, Ontario Medical Association, "Health Insurance."

3.30 p.m.—Dr. D. J. Galbraith, Commissioner, The Workmen's Compensation Board, "Compensation Board regulations as applied to the Hospital."

Evening Session:

6.45 p.m.Annual Banquet.

Welcome by Mayor of Toronto.

Greetings from Sister Organizations.

Entertainment, Mr. Stanley St. John's Orchestra, Mrs. M. J. McHugh, Dr. Harvey Doney.

Dance at conclusion of banquet.

* * *

Third Day, Friday, October 22nd.

Morning Session:

General Session—Chairman, Dr. J. H. Holbrook.

9.30 a.m.—Judge J. A. S. Plouffe, Sudbury, "Resumé of Hospital legal cases during the past year."

10.00 a.m.—Dr. A. H. Sellers, Medical Statistician, Department of Health, "Hospital Forms."

10.30 a.m.—Mr. C. J. Telfer, Inspector of Hospitals, "Problems Relating to the Co-operation of the Hospital and the Department of Public Health."

Afternoon Session:

Chairman, Dr. J. H. Holbrook.

2.30 p.m.—Reports of Sections.

(a) United Hospital Aids, Mrs. O. W. Rhynas.

(b) Trustees' Section, Mr. David Williams.

(c) Nurses' Section.

(d) Record Librarians' Section.

Reports of Committees:

"Legislation", Dr. John Ferguson.

General Business.

Election of Officers.

* * *

ONTARIO WOMEN'S HOSPITAL AIDS' ASSOCIATION

First Auxiliary formed 1865 — Association formed 1910

ANNUAL CONVENTION PROGRAMME

Sessions, October 20th, 21st and 22nd,
Royal York Hotel, Toronto, Ontario

Tuesday Evening, October 19th, Parlour B.—8.00 o'clock Executive Meeting. (The President of each affiliated group is a member of the Executive. Please plan to attend this meeting.")

First Day, Wednesday, October 20th, Parlour B. Session to open promptly at 10 a.m.

10.00 a.m.—Lord's Prayer in unison.

Address of Welcome — President, Mrs. Oliver W. Rhynas.

Reply—Mrs. Charles Taylor, St. Catharines (representing first Aid formed in 1865).

A word of greeting from the youngest Aid.

A moment of silence in honour of departed members.

Minutes:—Presented by Mrs. H. C. Allen, Guelph, Recording Secretary.

Treasurer's Report — Presented by Mrs. George W. Houston, Hamilton, Treasurer.

Announcement of Committees appointed at Executive meeting.

Committees—Press, Resolutions, Nominations, Scrutineers.

A Cordial Welcome . . .

awaits all Ontario Hospital Association Convention Delegates at our Booth Number 34, Royal York Hotel

BERKEL

A

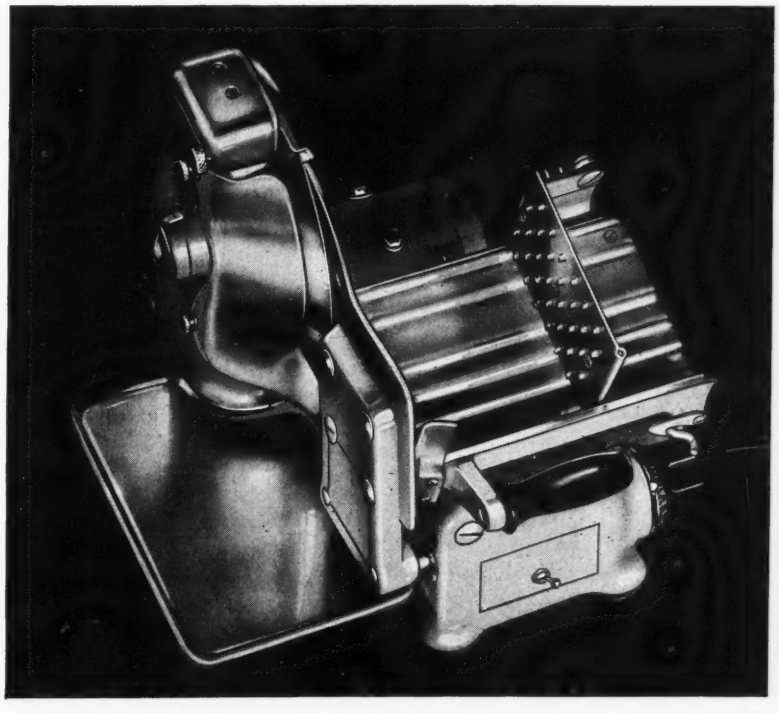
Complete

Line

of

Slicing

Machines



BERKEL

For

Slicing

Meat

Bread

Cheese

Fruit

Vegetables

Model 1100 Little Electric.

Visit our Booth, and see for yourself, by actual demonstration, how much more appetizing and palatable meals can be prepared with the aid of Berkel Food Slicers . . . . and at the same time, substantial savings established in the Food bills.

●

Oldest and Largest Exclusive Manufacturers of Slicing Machines in the World.

●

BERKEL PRODUCTS CO. LIMITED

Head Office and Factory

533-535 College Street - - - Toronto, Ont.

Branch Offices and Representatives from Coast to Coast

Round Table — Representative from each group will be given a brief period to explain the most outstanding ways and means of the year.
Discussion.

12.30 noon—Adjourn.
Ontario Hospital Association luncheon—Speaker, Dr. Basil McLean. (See Programme of Ontario Hospital Association).

2.30 p.m.—Re-assemble, Parlour B.
Resume Round Table discussion.
Report of committees.
Election of Officers.
New Business.
Adjourn at 4.30 p.m.

6.00 p.m.—Ontario Hospital Aids' Association Dinner. Ball Room, Convention. (Please assemble promptly).
Programme.
God Save the King.

Second Day, Thursday, October 21st.

Meeting as section of the Ontario Hospital Association Convention. (See General Programme).

* * *

SEVENTH ANNUAL CONVENTION
Canadian Association of Occupational Therapy
PROGRAMME

Friday, October 22nd.

9.00 a.m.—Registration.
9.30 a.m.—Annual Business Meeting.
11.30 a.m.—Papers:
(1) Miss H. Theodora Lambert, Supervisor, Employment and Home Industries, Occupational Therapy Centre, Montreal, "Home Industries and Employment for the Physically Handicapped."
(2) Dr. R. MacLachlan Franks, M.A., Ph. D., Toronto, "Numerical Limitations in the Treatment of Mental Diseases."

2.00 p.m.—Address of Welcome.
Dr. J. H. Holbrook, President of the Ontario Hospital Association.
Papers:
(1) Mrs. Mollie Johnson, Director, Border Branch Red Cross Society Workshop, Windsor, "Field of a Central Workshop in a Border City."
(2) Miss Dorothea Cooke, Director of Occupational Therapy, Worcester State Hospital: Convention Address, "Practical Occupational Therapy."
(3) Dr. Charles Hair, President, Academy of Medicine: "The Role of Occupational Therapy in Industrial Accidents."

4.30 p.m.—Ontario Society of Occupational Therapy. Annual Business Meeting.

7.45 p.m.—Annual Dinner at the Granite Club, St. Clair Ave. West.
Guest Speakers:
(1) Dr. Bernard McGhie, C.M., Deputy Minister of Health.

(2) Dr. Clarence Hincks, General Director of National Committee for Mental Hygiene and Canadian Committee for Mental Hygiene.

(3) Dr. W. J. Patterson, Assistant Surgeon at Royal Victoria Hospital and Shriner's Hospital for Crippled Children, Montreal.

Saturday, October 23rd.

9.30 a.m.—Round Table Conference.
Occupational Therapy for the Professional Person.
Financing an Occupational Therapy Department.
Occupational Therapy for the Patient Handicapped by Additional Disabilities.
Advisable Patient Quota per Therapist.
Therapy for the Child.
General Round Table—Synopsis of the Six Panel discussions.
3.30 p.m.—Tea at the Workshop.
4.30 p.m.—Annual Meeting of the Canadian Association of Occupational Therapy Alumnae.

* * *

ASSOCIATION OF RECORD LIBRARIANS OF ONTARIO

Royal York Hotel, Toronto, Ont.

Wednesday, October 20th, 1937.

Programme

9.30 a.m.—Registration
10.00 a.m.—12.15 p.m.—Presiding, Dr. F. W. Routley, Secretary-Treasurer, Ontario Hospital Association.
Address of welcome on behalf of the Association of Record Librarians of Ontario, Miss Isobel Marshall, President.
Address, Dr. J. Hardisty Sellers, Medical Statistician, D.P.H.
Round Table Conference, conducted by Dr. F. W. Routley.
12.30 noon—Luncheon with the Ontario Hospital Association. Special Table for the Record Librarians.
2.00 p.m.—3.15 p.m.—Executive Meeting.
8.00 p.m.—"Three Wishes of a Record Librarian", Miss Lillian Johnstone, Record Librarian, Hamilton General Hospital.
Address—Dr. H. F. Farquharson.

* * *

HOSPITAL SOCIAL SERVICE

Royal York Hotel, Toronto, Ont.

Thursday, October 21st.

Programme

Chairman—The Honourable Doctor J. A. Faulkner.
2.30 p.m.—Chairman's Remarks.
Social work and follow-up with carcinoma patients.
Value of Social work in Communicable Diseases.
Social Aspects of Children's Diseases.
The Place of the Volunteer in Hospital Social Work.
Discussion.

Alberta Hospital Association News

The Alberta Hospital Association welcomes into its membership the following hospitals:—

St. Paul's Hospital, Rimbey.
The Wayne Hospital, Wayne.
Coleman Miners' Union Hospital, Coleman.
The John Neil Hospital, Cold Lake.

* * *

St. Paul's Hospital, Rimbey, are considering the addition of a fifteen bed Children's Ward. This hospital has recently installed an ultra violet quartz lamp, the first of its kind to be installed in the province.

* * *

Work has started on the erection of a ten bed hospital at Fort McMurray. This should satisfy a long felt need.

* * *

A vote is being taken of the residents of the Carmangay and Claresholm Districts with a view to setting up Municipal Hospital Districts at these points.

* * *

Editor's Note:—The following article was written by Mr. James Rodgers for the Canadian Hospital at the request of the Alberta Hospital Association. In it, Mr. Rodgers explains in brief how Municipal Hospital Districts in Alberta are organized and established together with the service they render to people, far removed from large concentrated centres of population, in rural areas.

How Municipal Hospital Districts in Alberta are Organized

The Municipal Hospital's Act of the Province of Alberta provides that a number of Municipalities, both rural and urban, may conjoin themselves into a Hospital District for the purpose of providing efficient hospitalization at a low cost to all supporters under a scheme which is prepared to suit the requirements of the proposed district by a provisional board appointed by the Minister of Public Health, from the municipalities concerned.

The tentative scheme must receive the approval of the Minister before being completed and put into effect. General details include rate of taxation (limited by the Act to not higher than 03c per acre on rural lands and .003 mills on urban assessment) the territory which the district shall cover, site for the institution, amount of capital expenditure, schedule of fees, the authority of the Board to make contracts with municipalities, industrial classes, for those other than recognized hospital supporters by taxation or for Medical and Public Health services.

The completed scheme is submitted to electors within the prescribed municipalities in plebiscite form and if it receives a two-thirds majority the provisional board is replaced by a duly elected Board of Trustees composed of elected representatives from each subscribing municipality, the Board being empowered to carry out the provisions of the scheme and manage the affairs of the Institution.

Since 1919 there has been established twenty-two hos-

pital districts within Alberta, with a total bed capacity of 778. Statistics for 1935 disclose that 14,482 patients were admitted and given 158,926 days of hospitalization. In the same period 2,225 babies were born, 4,840 operations performed, 4,835 X-ray and 10,819 laboratory examinations given with a daily cost ranging from $1.98 to $3.71, or an average of $2.94. Spread in hospitalization rates is due to geographical position, services offered by various institutions and the different types of structure used. Total revenues of the 22 institutions amounted to $614,537 wtih operating costs of $523,394.

The Municipal Hospital project, financed as it is by general taxation, has enabled people living in isolated areas to have a service which compares favourably with that of the larger urban hospital at a very low rate. It has likewise been of invalubale service to the Medical profession providing more efficient nursing care and more complete equipment than could be at the disposal of practitioners in the small, scattered communities across length and breadth of the province. With the Municipal Hospital as a complete unit, practitioners have been in a much better position to establish themselves and build up their practices.

Despite light crops, drought, hail, pests, the reduced price for grain, livestock and produce and other disheartening factors, Alberta's Municipal Hospitals have weathered the handicaps. Financing at times has been difficult but with the turn to better crop and price conditions there would appear to be a brighter future in store for these institutions as Western Canada has a habit of returning to normalcy at surprising speed.

(Statistics contained in the above article were obtained from the annual report of the Department of Public Health, Province of Alberta. The article itself reflects the personal opinion of the writer.)

Research in Rheumatism

It is reported that the University Hospital at Ann Arbor, Michigan, is undertaking a very important piece of research work. Rheumatism is one of the diseases about which there have been so many theories and so much discussion that the study of this disease, which is being undertaken should be welcomed. It is planned to devote several years to research in order to attempt to determine the causes and arrive at a method of treatment. This extensive work is being carried out through revenue provided by the Rackman Fund, amounting to $10,000 per year.—Hospital Management.

WE WOULD LIKE TO KNOW —

The Editorial Board will be pleased to answer in this column any question they can that will be of general interest to hospital workers. Kindly mail questions directly to the Editor.

Q. Should the chief orderly be responsible to the nursing head?

A. In view of the increasing demands being made on the nursing heads it would seem reasonable to suppose that she should be relieved of this additional responsibility. This practice is still in existence in a few hospitals but is not the recognized practice. The chief orderly has frequently supervision over male cleaners in addition to the orderly service. While the nursing staff can assist in the training of the orderlies the chief orderly should be responsible to the superintendent. The utmost co-operation should exist between the chief orderly and the nursing head.

Q. What are the advantages of an out-patient department from an economic point of view?

A. 1. Avoids quite frequently the necessity of admission.

2. Definitely reduces the in-patients days in not a few conditions.

3. Renders an adequate service to the patient at a minimum cost.

4. Permits a hospital to care for a much greater number of patients adequately.

5. Provides when needed the Records and Histories essential to the best in-patient service.

Q. Is it economical to have cafeteria service for staff in a hundred bed hospital?

A. It depends upon the existing food service organization. There is no doubt but that cafeteria service is more economical to operate and permits a menu of greater variety to be served, but unless the present plant permits you to convert to cafeteria service without too great a capital outlay the venture should be considered very seriously before a change is made.

Q. What regulations are in effect governing the use of electrical apparatus that interferes with radio broadcasting.

A. No regulations are at present in effect but are in the process of drafting—they will be enforced under clause 23 of the Canadian Broadcasting Act of 1936. This subject was discussed fully at the Canadian Hospital Council, Ottawa, September 8th and 9th, and will be recorded in an early issue of "Canadian Hospital."

Q. Should an admitting officer be allowed to report accidents to the press?

A. If an admitting officer is well trained there is no reason why she should not report accidents. It is recommended that a definite code covering such information be issued from the administration office after a conference with the local press stating frankly what information is to be given and the manner of giving it. The admitting officer may then be entrusted to follow the code.

Ammonium Mandelate Squibb (Mandam)

Ammonium Mandelate Squibb (Mandam) is a new and very effective urinary antiseptic for oral administration, intended for the treatment of acute and chronic cystitis, pyelitis and other infections of the genito-urinary tract. It is supplied in compressed tablet form—the first product of its kind available in this form, the other mandelic acid preparations being available only as elixirs and syrups.

In compressed tablet form, Ammonium Mandelate Squibb is simple, agreeable and convenient to administer and is potent. The tablets are tasteless and are unaffected by moisture (unless exposed to the air for a considerable period of time), characteristics which have been produced without sacrifice of their solvent properties in the fluids of the gastro-intestinal tract.

Ammonium Mandelate Squibb (Mandam) is offered in tablets of 7½ gr. (0.5 gm.) each, in bottles of 200 and 1000; and in tablets of 3¾ gr. (0.25 gm.) each, designed especially for infants and children in bottles of 100 and 500. A twelve-days' supply of Nitrazine Test Paper and a colour chart are supplied with each bottle of 100 and 200 tablets to facilitate testing the acidity of the urine.

(Mandam and Nitrazine are trade-marks of E. R. Squibb & Sons of Canada Ltd.)

Thermos Service for Hospitals

The serving of drinks in the hospital is a matter of paramount importance. They should be either piping hot or refreshingly cold. In between temperatures dissatisfy. Just imagine serving tepid drinks to your patients during the recent summer torrid heat! On the other hand, the institution that served appetizing drinks, properly chilled, added considerably to the welfare of both patients and staff.

Keeping drinks cold or hot is said to be easy nowadays with the many types of Thermos jugs and tubs available for all uses. Every size requirement of the hospital has been studied and provided for. That's why so many institutions use Thermos containers. Private room service can be given an "added touch" by their use and kitchen service made, easier by this method of keeping drinks in readiness, just as your patients want them, it is claimed.

From the management side, Thermos offers a decided advantage because their patented Stronglas filler is harder wearing, cuts down breakage and stays in service more continuously, they state.

Yes, serving drinks correctly is an art and is well worth the small expense involved.